350 Wireless Blvd Ste 200, Hauppauge, NY 11788
Ph: (631) 435-8700 Fax: (631) 435-8777
Email:support@payrolldynamics.com

FSA MEDICAL & DEPENDENT CARE ELECTION FORM

You are required to complete this election form at the beginning of each Plan Year.
A new election form should also be completed if you require a change to your annual election amount(s).

Plan Year____________________ **Company Name**____

Part A. Employee Information (All Fields Are Required)

Name____Date of Birth____________________Date of Hire__________________

Address____City, State, Zip____

Social Security #_______________________________________Phone Number____

Email____

Part B. Elections (Select one or more options)

Medical Care Pre-tax Annual Election_____________________ Plan Year________________Annual Limit____________________

Dependent Care Pre-tax Annual Election___________________ Plan Year________________Annual Limit____________________

Part C. Benefits Card

Do you want to order a benefits card associated with your account? _____Yes _____No

A $15 charge will be assessed for lost or stolen cards that need to be cancelled and reissued. A $10 expedited shipping charge is applicable if rush shipping is selected.

If you wish to have a separate card issued for a dependent, a $15 per card fee applies.

Part D. Plan Agreement I understand that: For Calendar Year Plans

1. My compensation each pay period will be reduced by the total amount above divided by the number of company pay periods in the year (or remaining in the year if you are becoming a participant at any time except at the beginning of a plan year).
2. I cannot change or revoke this benefit election as of any date prior to the next January 1st, unless I have a change in my family status or Life Change Event (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Administrator determines will permit a change or revocation of an election).
3. Prior to January 1st each year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not complete and return a new Election Form at that time, I will be treated as having elected cash instead of salary reductions for the new plan year (January 1st to December 31st).
4. The administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the provisions of the Plan if it is believed to be advisable in order to satisfy certain provision of the Internal Revenue Code.
5. This benefit election will automatically be cancelled as of the date of my termination of employment. However, if you continue to be covered under the Employer's medical plan or plans, you may be able to continue participation in this plan during your period of coverage. You will receive information on this option when you terminate service.

I hereby authorize my employer to deduction from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan.

Employee's Signature____ Date____________________

Accepted and agreed to by (Employer's Signature)___________________________ Date____________________