



P.O. Box 7809 * Visalia, CA 93290

Section 125 Election Agreement

I, the undersigned employee of _____ understand that effective _____ I am eligible to participate in the Section 125 Plan sponsored by my employer. I hereby make the following elections regarding the benefits available to me under the Section 125 Plan. I am further making election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, such amount to be deducted in equal sums from my regular paychecks commencing with my paycheck dated _____.

PRE-TAX PREMIUM PAYMENT BENEFITS				I elect to participate		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group Medical	\$ _____	Per Pay Period	Group Vision	\$ _____	Per Pay Period		
Group Dental	\$ _____	Per Pay Period	Other _____	\$ _____	Per Pay Period		
HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) BENEFITS				I elect to participate		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(See reverse for description of each of the following classifications)</i>							
<input type="checkbox"/> (a) General Purpose Health FSA Family Coverage	\$ _____	Per Pay Period					
<input type="checkbox"/> (b) Employee-Only Health FSA Coverage	\$ _____	Per Pay Period					
<input type="checkbox"/> (c) Employee-Plus-Children Health FSA Coverage	\$ _____	Per Pay Period					
<input type="checkbox"/> (d) Limited (Vision/Dental/Preventative Care) Health FSA Coverage	\$ _____	Per Pay Period					
PLEASE INDICATE:							
My spouse participates in an HSA							
<input type="checkbox"/> Yes <input type="checkbox"/> No							
DEPENDENT CARE (DCAP) BENEFITS				I elect to participate		<input type="checkbox"/> Yes <input type="checkbox"/> No	
DCAP Coverage	\$ _____	Per Pay Period	(not to exceed \$5000, or \$2500 if married filing separately)				
HEALTH SAVINGS ACCOUNT (HSA) BENEFITS				I elect to participate		<input type="checkbox"/> Yes <input type="checkbox"/> No	
HSA Coverage	\$ _____	Per Pay Period	(annual maximum is the lesser of the deductible under my High Deductible Health Plan coverage or the applicable statutory maximum for my HDHP coverage type (i.e., single or family).				

Employee's Last Name		First Name		Mid. Int.	Social Security No.	
Employee's Address Street			City		State	Zip
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		Date of Hire	Monthly Gross Pay

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and is consistent with a change in family status (e.g., marriage, divorce, birth or death of spouse or child).

I certify the above information to be correct and true. Any dependents for which I have selected the dependent care benefit reside with me in a parent-child relationship and/or are legally dependent on me for their support. I understand that any amounts remaining in my FSA and/or DCAP account that are not used for eligible expenses incurred during the plan year or the grace period will be forfeited in accordance with plan provisions.

Signature: _____ Date _____

Waiver of Participation

I acknowledge that I have been given the opportunity to participate in the Section 125 Plan and I choose not to participate at this time. By waiving participation, I realize that I will not again become eligible to participate until the next Plan Year.

Signature: _____ Date _____

HEALTH FLEXIBLE SPENDING ARRANGEMENT (FSA)

General-Purpose Health FSA Coverage will prevent an individual and their spouse from being eligible for HSA contributions. If either you or your spouse participate in an HSA, you cannot participate in a General Purpose Health FSA. Please see below for a description of each FSA option and choose the option that is appropriate for you.

(a) General Purpose Health FSA Family Coverage – This option is for an employee (and spouse) who is not interested in contributing to an HSA. Reimbursements for the employee, spouse, and children are permitted with this FSA option.

(b) Employee Only Health FSA Coverage – This option is for an employee who is not interested in contributing to an HSA, but whose spouse wants to remain eligible to contribute to an HSA, which the spouse could not do if the employee participates in a General-Purpose FSA that covers the whole family. Reimbursements for employee expenses only are permitted with this FSA option.

(c) Employee-Plus-Children Health FSA Coverage – This option is for an employee who is not interested in contributing to an HSA, but whose spouse wants to remain eligible to contribute to an HSA, which the spouse could not do if the employee participates in a general-purpose FSA that cover the whole family. Only reimbursements for employee and eligible children expenses (*but not spouse*) are permitted with this FSA option.

(d) Limited Purpose Health FSA Coverage – This option is for an employee who wishes to remain HSA eligible while using a health FSA to pay for his or her family's dental, vision, and preventive care expenses.

Important Information for Health FSA Participants: HSA Benefits cannot be elected in addition to Health FSA Benefits unless the Limited Health FSA Coverage Option is selected. In addition, because the Health FSA includes a grace period, if you have an election for Health FSA Benefits (other than the Limited Health FSA Option) that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, even if no amounts remain in your Health FSA Account at the end of that Plan year.