MidAmerica
Administrative & Retirement Solutions

Flexible Benefits (125) Plan Enrollment Form

for period January 1, 2017 - December 31, 2017

I. GENERAL INFORMATION

Employer Name			
Employer ID			
Employee Name (Last Name, First Name, Initial)		Social Security Number	
Address	City	State	Zip Code
Home Telephone Number	Work Telephone Number	Date of Birth (Mo/Day/Yr)	Date of Hire (Mo/Day/Yr)
Email Address			

II. FLEXIBLE SPENDING ACCOUNTS

Choose carefully as your election is binding for the entire Plan Year. Any unused dollars remaining in your Flexible Spending Account at the end of the Plan Year will be forfeited unless your plan has permitted a carryover option, allowing you to carry over a portion of your health FSA funds to the following Plan Year. Expenses/claims must be incurred during the Plan Year in order to be eligible for reimbursement. See the Summary Plan Description for more details.

☐ I hereby elect to participate in the Flexible Spending Accounts as indicated below.

☐ I hereby elect NOT to participate in the Flexible Spending Accounts as indicated below.

SPENDING ACCOUNTS – As a participant I hereby elect to participate in the Flexible Benefits Plan and therefore authorize my Employer to reduce my wages on a pretax basis during each payroll period in the following amount. I understand this election will be in effect for only the current plan year. I understand I must complete this each year.

	PER PAY PERIOD		# PAY PERIODS		ANNUAL ELECTION
HEALTH CARE REIMBURSEMENT	$_____	X	_____	=	$_____
DEPENDENT CARE REIMBURSEMENT (Day care expenses incurred during employment hours)	$_____	X	_____	=	$_____

Effective date of coverage: January 1, 2017.
My pay schedule is: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

III. AUTHORIZATION AND ACKNOWLEDGMENT

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket medical, and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Account Plan for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

DATE _____ EMPLOYEE SIGNATURE _____

MidAmerica Administrative & Retirement Solutions is the third party administrator for your Plan
PLEASE RETURN THIS FORM TO YOUR EMPLOYER
Should you have any questions regarding the enrollment of this Plan, please contact MidAmerica at 1-855-329-0095.