



First
Concord
Benefits
Group

I.R.C. Section 125 Enrollment Form

P.O. Box 67220
Lincoln, NE 68506

Phone: 402-423-4454
Fax: 402-423-4549

EMPLOYER: Community Action Partnership of Mid-NE

PLAN YEAR: Jan 1, 2012 to Dec 31, 2012.

www.ezflexplan.com/fcbg

Name (please print)		Marital Status	Sex	Date of Birth Mo/day/year	Social Security Number	
Home Address		City	State,	Zip	Home Phone Number	No. of pay periods 12 for regular staff 9 for HS partial year

A. Unreimbursed Healthcare Spending Account

This account allows you to pay for out-of-pocket medical, dental, hearing and vision expenses with pre-tax dollars. EXAMPLES: deductibles, co-insurance, prescriptions. (See reverse side - Part A)

***For employees not participating in an HSA-** Do you have an HSA through a spouse? If so, you may not be eligible for this section. Please check with your HSA provider.

\$9,500 Maximum

Election Amount

Annual Per Pay Period

\$	\$
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B. Dependent Day Care Spending Account

This account allows you to pay for day care expenses on a pre-tax basis throughout the plan year. (See reverse side - Part B)

Election Amount

Annual Per Pay Period

\$	\$
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C. Personally Owned Insurance Spending Account

This account allows you to pay for 'Employee Paid' personally owned insurance premiums on a pre-tax basis. (See reverse side - Part C)

Election Amount

Annual Per Pay Period

\$	\$
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D. Group Insurance Premiums

This account allows you to pre-tax your group-sponsored insurance plans. (Group term life up to a \$50,000 maximum). (See reverse side - Part D)

Election Amount

Annual Per Pay Period

\$	\$
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NOTE: if your group insurance premiums change during the plan year, your employer will automatically adjust this without the need for a new enrollment form.

I Understand that:

- The company and I hereby agree that my cash compensation will be reduced by the amounts set forth.
- This is an irrevocable election and can only be changed if I have a change in status as described in my employer's Summary Plan Description. Furthermore, I agree that any change in my election must be consistent with that change in Status.
- Any amounts remaining in my accounts at the end of the plan year will be forfeited.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous election and will terminate on the earlier of (1) the end of the plan year, (2) when I fail to pay the required amount, or (3) termination of the plan.
- My employer may reduce or cancel this election as necessary to comply with the provisions of the Internal Revenue Code.

PLEASE CHECK ONE OF THE FOLLOWING

I have read the above and would like to **participate** in the plan as described.

I have read the above and elect to **waive** participation in this plan at this time. I understand that I cannot elect pre-tax benefits until the next anniversary date. I understand that I may elect similar coverage(s) on an after-tax basis, and my after tax coverages shall be outside the plan.

Employee Signature

Date

NOTE: *There may be a limit on the amount which can be used for certain benefits. You should review your Summary Plan Description and ask your Administrator any questions you may have.*

Part A. *Unreimbursed Healthcare Spending Account*

Examples of these expenses may be, but are not limited to insurance deductibles, medical exams, hearing, dental expenses, vision expenses, orthodontia and Prescription Drugs. All health care expenses must be for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body to be a qualified health care expense under the plan.

Part B. *Dependent Day Care Spending Account*

Only those dependent care expenses which allow you (and your spouse if you are married) to be gainfully employed are eligible. This excludes care which is primarily for medical or educational purposes.

Eligible Dependents - Dependent children under age 13, or any other dependent who is incapable of caring for himself or herself, whose principal residence is your home and you can claim as a dependent on your federal tax return.

Eligible Expense - Reimbursement is limited to the income of the lower earning spouse and also \$5,000/year; \$2,500 if married, filing a separate return. Married employees in separate plans can only be reimbursed in total \$5,000. The reimbursement amount may not exceed the employee's salary; or for married employees, the lesser of the spouse's salaries (subject to certain exceptions). If your spouse is a full time student or incapable of caring for himself or herself, the maximum is \$200 per month for one child or \$400 per month for two or more children.

Eligible Providers -

- A licensed day care center which cares for six or more persons
- A unlicensed provider caring for less than six persons
- An in-home provider, as long as that provider is not your child under age 19 or someone you or your spouse can claim as a dependent for tax purposes.

For more information, see IRS publication 503, available from your local IRS office.

Part C. *Personally Owned Insurance Spending Account* - Some examples of these expenses may be any personally owned health or disability insurance. This does **not** include the amount that your spouse pays their employer for group coverage under their plan. Life insurance is **not** an eligible expense in this account. IRS regulations now require this coverage to be maintained or owned by the employee – not a spouse or dependent.

Part D. *Group Insurance Premiums* - Group term life up to a maximum of \$50,000 may be deducted pretax. Please note that most health insurance gives you life insurance as well. This needs to be noted in your calculations. (i.e. medical life insurance \$10,000 therefore \$40,000 term life may be deducted). Dependent life insurance is not eligible for pretax deductions.

All claims will be paid from actual bills, or copies of actual bills. For Unreimbursed Healthcare Spending Account claims you may also submit a copy of your EOB form from your insurance carrier. These must contain the name of the provider of service, date(s) that the services were provided and the amount charged. They must be attached to a completed First Concord Benefits Group "Claim for Reimbursement" form.