Western North Carolina Conference
The United Methodist Church

Flexible Spending Account Plan
ELECTION FORM

PLEASE PRINT CLEARLY

Plan Information

Sponsor: _____ Plan Year: _____

Employee Information

Name: _____ LAST Four of Social Security Number: _____

Address: _____
Street City State Zip Code

*Email: _____ Phone: _____

*We use this to send notices and monthly statements to you.

Election Information

✓ I hereby elect to participate in my employer's Flexible Benefits Plan as indicated below:

PREMIUM CONVERSION ACCOUNT	AUTOMATIC	No election required. Your portion of any premium charged for group insurance you select will be deducted on a pre-tax basis.

CHECK ELECTIONS OPTION(S) AND FILL IN AMOUNTS (IF APPLICABLE)

Benefit Election Options Election Deduction

MEDICAL
Spending Account

☐ Yes
☐ No

$ _____ Per Pay Period
x _____ Number of Pay Periods
= _____ Total Annual Contribution

DEPENDENT CARE
Spending Account

☐ Yes
☐ No

$ _____ Per Pay Period
x _____ Number of Pay Periods
= _____ Total Annual Contribution

Participant Election Authorization

*An **additional** card should be issued to the following person authorized to use the above FSA accounts:*

Name: _____ Social Security #: _____ Relationship: _____

You are responsible for notifying TEA if the above card privileges should be revoked at any time during the Plan Year.
Cards issued are valid for a period of 3 years from the date issued. If you already have cards, you do not need to request new cards.

I have reviewed and understand the terms and conditions outlined on the reverse side of this form. I understand that I cannot change or revoke this election at any time during the Plan Year unless I have a qualified change in status allowed under the Plan.

Participant's signature: _____ **Date:** _____

See Terms and Conditions on reverse

For HR Use Only

Participant's Effective Date: _____ Payroll Cycle: _____ Date of First Deduction: _____

HR Rep Initials: _____

Terms And Conditions

Qualifying Medical Care and Dependent Care Expenses: I understand that reimbursement will be available only for "qualifying medical care expenses" as determined by my company's plan. These expenses must be incurred while I am enrolled in the Plan. I agree to notify the Plan Sponsor or The Employers Association (TEA) if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to repay the Plan on demand by way of check or payroll deduction for any expense that is not allowed. If any legal or collection action is necessary to recover funds that should have been repaid to the Plan, I agree to reimburse the plan for any and all expenses, including legal fees, incurred in seeking reimbursement. I attest that I understand claimed medical expenses can not be reimbursed under the Healthcare FSA Plan if the expense has been or will be paid in the future by any other plan and **acknowledge that the medical expenses have not been reimbursed or are not reimbursable under any other insurance plan coverage.** I further acknowledge that I am responsible for keeping all receipts verifying all eligible expenses claimed under the Plan and must submit such receipts to TEA for claims substantiation, upon request.

Participation Rules: I understand that reimbursement account eligibility, enrollment and benefits information is available from my Plan Sponsor. I authorize payroll deductions for the benefit elections indicated on this Election Form. I understand that I cannot change or revoke this agreement at any time during the Plan Year except for the occurrence of a change in status as defined by the Plan. In the case of a change in status, I must complete a Change Form no later than 30 days after the date the change occurs if I want to change my reimbursement account elections or amounts. Any amounts remaining in the account(s) represented by this Election Form at the end of the Plan Year, past the claims filing limit, will be forfeited to the Plan under the guidelines of the Internal Revenue Code.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE PLAN SPONSOR'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME. THIS PLAN SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

Authorization

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me my past, present, or future physical or mental health or condition; (i) the provision of healthcare to me; or (ii) the past, present, or future payment for the provision of healthcare to me.

The Employers Association (TEA) is authorized to use or disclose my protected health information for the purpose of administering my account. ***I further authorize TEA to release my protected health information to my spouse and/or my tax dependents. I understand that I may decline disclosure of my protected health information (to my spouse and/or tax dependent/s) by submitting a written notification to TEA.***

I understand that I may revoke this authorization at any time by sending a written notification to TEA, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that TEA already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage by TEA and, by law, TEA has a right to contest the coverage.

I understand that this authorization expires upon termination of my employer's plan.

This summary of the Company's FLEX plan represents only a summary. In case of a discrepancy between the information provided herein and the Plan document, the Plan document representation will rule. Nothing in this brochure should be construed as a contract or guarantee of continued employment.