Morehouse Parish School Board
Flexible Benefit Plan – Election Form

PARTICIPANT INFORMATION			
Social Security Number	**First Name**	**MI**	**Last Name**
Home Address: Street / City / State / Zip		**Email Address**	**Home Phone**
Sex: ☐ Male ☐ Female	**Date of Birth: / /**	**Date of Hire: / /**	**Salary: $**

This form is used to make your flexible spending account elections for the Flex Plan. Your employer will use the form to make deductions from your paycheck. Upon submission of proof, you will be reimbursed for those eligible expenses elected on the form.

I understand that this program allows employees to select their statutory non-taxable benefits within the guidelines of the Internal Revenue Code. I understand that there may be a reduction in social security benefits due to decreased social security contributions.

I understand that any expenses reimbursed through this plan may not be used on my income tax return for tax deduction or tax credit purposes. I agree that if I am using a debit card, the card will only be used to pay for eligible medical care expenses for myself and my spouse or dependents and the expenses paid with the card have not been and will not be reimbursed by another health plan.

I understand that 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 consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of child) or termination of employment of myself or my spouse.

I understand that any contributions made to the Plan will be lost if I do not submit reimbursement for expenses as outlined in the Summary Plan Description.

Listed below are the benefits available under the Plan. Please indicate which benefits you want to elect. The election of coverage and the pre-tax treatment of premiums will remain in effect for subsequent years until changed by you. The non-premium elections will only remain in effect for this Plan Year. Any change in the pre-tax treatment or coverage will require a new election form.

Benefit Selection	Pay Frequency		Per Pay Deduction Pre-tax	Per Pay Deduction Post Tax	Effective Date
	Monthly	Semi-Monthly			
Eligible Medical Out-of-Pocket Expenses ($2500 max)					
Dependent Care Expense ($5000 max)					
Medical Plan					
Employee Life					
VSP Vision					
Southern National Dental					
Assurity Cancer					
Dependent Life					
Standard Disability					
Unum Life					
American Heritage Life					
STATE/OGB Dep Life					

I hereby elect _____ to participate _____ not to participate in the Flexible Benefit Plan and authorize my employer to reduce my compensation as shown above. I understand that if I do not participate I will not be eligible to participate again until the following Plan Year. I understand that my termination of employment will terminate participation in the Flex-Plan.

_____ _____

Participant's Signature **Date**

Participant		Social Security Number	

NOTICE OF OPPORTUNITY TO ENROLL

Section 2714 of the Affordable Care Act expands the availability of coverage for group health plans to adult children of employees until the child attains age 27. Both coverage under an employer-provided accident or health plan and amounts paid or reimbursed under such a plan for medical care expenses of an employee, an employee's spouse, an employee's dependents (as defined in Section 152, determined without regard to Section 152(b)(1), (b)(2) or (d)(1)(B)), or an employee's child (as defined in Section 152(f)(1)) who has not attained age 27 as of the end of the employee's taxable year are excluded from the employee's gross income. These same rules apply to Cafeteria Plans, Flexible Spending Arrangements, and Health Reimbursement Arrangements.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 27 are eligible to enroll in the **Morehouse Parish School Board Cafeteria Plan**. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective retroactively to **July 1, 2011**. For more information contact your Human Resources Director at (318)281-5784.

Please provide the information requested below for all legal dependents and adult children below age 27

Name	Date of Birth	Relationship	Gender