Section 125 Flexible Benefit Plan Elections

SECTION A ***(Please Print)***

Employer Name:		Plan Entry Date:	
Participant Name		Social Security No. — —	
Mailing Address	City	State	Zip
Email Address:		Phone Number:	
Payroll Cycle: ☐ Monthly ☐Semi-Monthly ☐Bi-Weekly ☐ Weekly		Number of Contribution Periods: _____	

SECTION B

Eligible Expenses	Per Pay Period	Per Plan Year
Health Insurance Premium	**$**	**n/a**
Dental Insurance Premium	**$**	**n/a**
Vision Insurance Premium	**$**	**n/a**
_____ Premium	**$**	**n/a**
Dependent Care Reimbursement: not to exceed the lesser of: $5,000; your salary; your spouse's salary; or your expenses	**$**	**$**
Health Care Reimbursement	**$**	**$**

SECTION C

☐ **I DO** ☐ **I DO NOT** hereby authorize my employer to make periodic salary reductions from my paycheck for the Elections specified above in an amount equal to the premiums required for the coverage elected above plus the specific dollar amounts, if any, elected for the flexible spending accounts. The salary reductions shall be made in substantially equal amounts, to the extent administratively feasible. I further authorize Kazdon, Inc. to disburse funds in accordance with the Plan and my elections. I further acknowledge that:

- I must submit a Reimbursement Request to receive reimbursement from my flexible spending accounts.
- My elections, including coverage types, cannot be altered without a qualified "Change in Status".
- My participation in the insurance premium portion of the plan, if previously elected, will **Automatically Renew** for each plan year unless I modify or revoke my elections during the open enrollment prior to each plan year.
- Flexible Spending Accounts will not automatically renew.
- The unused balance of the flexible spending account(s) is forfeited at the end of the plan year.
- Reimbursement Requests must be sent to Kazdon, Inc. no later than **60** or **90** days following the end of the plan year. I will verify with my employer which is applicable to our plan..

I hereby verify that, if I have elected salary reduction contributions for the Dependent Care benefit in amounts, which exceed $2,500 in one calendar year, and if I am married, I will file a joint income tax return with my spouse.

Participant Signature	Date	HR Representative

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