

**Oklahoma United Methodist Conference**

Local Church/Agency Flexible Spending Account Agreement

To be completed and filed by the Local Church/Agency sponsoring Medical Benefits.

***Copies of this form are to be kept with the Employee & the Local Church/Agency***

ELECTION PERIOD: From \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/2017 through 12/31/2017

**Please Print**

|  |  |
| --- | --- |
| Employee Name **(Last) (First ) (Middle)**  | Church Name: |
| Social Security Number: | Date of Birth:  |
| Home Address: **(Street Address, City, State, & ZIP)** | Home Phone Number:  |
| E-mail Address:  | Date of Hire: |

I elect to have my compensation reduced during the election period to fund the benefits I have selected below under the above referenced Plan. I realize the election for Medical Expense may not be revoked or changed unless it is on account of and **consistent** with a change in status of one of my dependents, my spouse, or myself such as marriage, divorce, annulment, legal separation, death of spouse; change in number of dependents due to birth, adoption, placement for adoption, death, or a court ordered change in custody or medical obligations; change in employment status that affects eligibility for my spouse, my dependents, or myself; termination or commencement of employment, going from part-time to full-time and vice-versa, strike or lock-out, commencement of or return from an unpaid leave of absence, change in worksite or going from salaried to hourly or vice-versa (must affect eligibility); change in eligibility of my dependent(s) on account of attainment of age, student status or any similar circumstance, or either losing or gaining eligibility, becoming entitled to receive Medicare or Medicaid or changing residence that affects eligibility. (Changes in insurance premium rates or plan coverage do not entitle you to change your medical expense reimbursement or dependent care election).

**Please note: If my employment terminates for any reason, I realize that expenses incurred after my date of termination will not be eligible for reimbursement. Date of termination is the 1st of the month following termination of employment or retirement. Participants will have 90 days after date of termination to submit claims.**

|  |  |  |
| --- | --- | --- |
| I request the following amount(s) to be deducted pre-tax from my salary: (Please **circle** the appropriate level of coverage below and enter the monthly amount deducted)  |  | **Employee Cost Per Month**  |
| **All Medical Plan networks are administered by Blue Cross & Blue Shield of Oklahoma** Please circle the plan desired by the employee * **Choice PPO**
* **Preferred PPO Plan**
* **Choice High Deductible Health Plan**
* **Preferred High Deductible Health Plan**
* **Preferred PPO Plan**

**Please list the monthly amount deducted from the employee’s salary.** Level of coverage **(Full Cost will be billed to the employer)*** **Single**
* **Two Party**
* **Family**
 |  | $ |
| **PPO Plans Only**Medical Expense Reimbursement Program **(NOT to exceed $2,550 annually) “Benny Cards”**  |  | $ |
| **High Deductible Health Plans Only**Health Savings Account(HSA) Contributions **(Annual** **Limits vary and determined by IRS)** |  | $ |
| Dependent Care Assistance Program **(NOT to exceed $5,000 annually)** |  | $ |
| **Voluntary** Dental premium: Participant only: **$37.20** Participant + spouse: **$74.40** Participant + child(ren): **$105.52** Participant + Family **$142.70** |  | $ |
| **Voluntary** Vision premium: Participant only: **$9.38**, Participant + one dep. **$13.61**,  Participant + family **$24.40** |  | $ |
|  **Total monthly deduction amount:** |  | $ |

I realize that all dependent care and medical expenses must be incurred by me or my dependents and must have been incurred during the election period. I also realize that I can only be reimbursed for dependent care expenses during the hours of the employment of my spouse, if married, and myself and only up to the amount of funds available in my dependent care account at that time. I also realize that if the total calendar year Dependent Care Assistance Program reimbursement exceeds the lesser of my or, if married, my spouse's earned income, then the excess amount will be taxable to me. At the end of each year, I will file Form 2441 with the Internal Revenue Service reporting the name, address and tax identification number of the person or organization providing dependent care services. I realize that amounts selected for one benefit cannot be transferred to another benefit.

I realize that amounts selected for one benefit cannot be transferred to another benefit. I am also aware that the “Grace Period” ends March 15th after the end of the Plan Year during which time I can continue to incur claims and use amounts remaining in my Medical Expense Reimbursement Account or Dependent Care Spending Account. I realize that I forfeit any amount not paid to me within 30 days after the end of the Grace Period or April 14th.

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**Signature of Participant** **Date**

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**Approved By Date**

Med. Exp. Reimbursement / Dependent Care Plans Administered by:

 Keystone Flex Administrators, LLC

[www.keystoneflex.com](http://www.keystoneflex.com)

(Phone: 405-285-1144 / Toll Free Phone: 866-680-8308)

Health Savings Accounts Administered by:

HSA Bank

<http://www.hsabank.com>

(Toll Free Phone: 800-357-6246)