



Planned
Benefit
Systems

FLEXIBLE BENEFITS PLAN ELECTION FORM

PLAN INFORMATION

EMPLOYER NAME: _____

PLAN YEAR: _____

EMPLOYEE INFORMATION

FIRST NAME _____ MI _____ LAST NAME _____ SOCIAL SECURITY NUMBER _____

ADDRESS – NUMBER AND STREET _____ CITY _____ STATE _____ ZIP CODE _____

(_____) _____ / ____ / _____
DAYTIME PHONE NUMBER _____ E-MAIL ADDRESS¹ _____ DATE OF BIRTH _____

SPOUSE INFORMATION

Yes, please issue an additional *MBI Benefits Card*TM to my legal spouse at no charge.²

SPOUSE FIRST NAME _____ SPOUSE MI _____ SPOUSE LAST NAME _____ SOCIAL SECURITY NUMBER _____

ELECTION INFORMATION

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

HEALTH CARE SPENDING ACCOUNT

You can elect a maximum of \$ _____ per Plan Year.

\$ _____ \$ _____
PER PAY PERIOD* ANNUAL

DEPENDENT CARE SPENDING ACCOUNT

You can elect a maximum of \$5000 per Plan Year if single parent or if married and filing a joint return; \$2500 if married filing separately.

\$ _____ \$ _____
PER PAY PERIOD* ANNUAL

*Please check with your employer to determine the number of remaining payroll deductions if you enroll after the beginning of the plan year.

REIMBURSEMENT INFORMATION

I (we) hereby authorize Planned Benefit Systems, Inc., hereinafter called PBS, to initiate credit entries to my (our) account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until PBS has received written notification from me (or either of us) of its termination in such time and in such manner as to afford PBS and DEPOSITORY a reasonable opportunity to act on it.³

ACCOUNT NUMBER: _____

ROUTING NUMBER: _____
(NINE DIGITS)

BANK NAME: _____

CHECKING ACCOUNT

SAVINGS ACCOUNT

EMPLOYEE AUTHORIZATION

I have reviewed and understand the Terms and Conditions on the following page of this form and as outlined in my employer's Summary Plan Description.

EMPLOYEE SIGNATURE: _____ DATE: _____

FOR EMPLOYER USE ONLY

DIVISION / LOCATION NAME: _____ DATE OF HIRE: _____ DATE OF ELIGIBILITY: _____

DATE OF FIRST DEDUCTION: _____ TOTAL NUMBER OF PAYROLL DEDUCTIONS: _____

Please review the Terms and Conditions on the following page and return this form to your employer.

Terms and Conditions:

¹ E-Mail

By providing your e-mail address you agree to receive FSA correspondence via e-mail. E-mail regarding your FSA plan(s) will be sent from help@cci-pbs.com; please add this e-mail address to your e-mail address book to ensure receipt of all correspondence. You can change/delete your e-mail address by logging on to www.mbicard.com or by contacting the PBS, Inc. Customer Service Department. PBS, Inc. reserves the right to utilize an e-mail address that may be provided to us by your employer. PBS, Inc. will not share e-mail information with ANY outside source.

² Spousal Card Request (Applicable only if employer elects to use *MBI Benefits Card*[™])

By providing spousal information and signing the enrollment form you authorize and understand that one additional MBI Benefits Card will be issued under your flexible spending account. Card will only be issued to *legal* spouse as defined by IRS(c) 152. Use of the card will directly affect your account balance. You are fully responsible to ensure that your spouse complies with the rules and regulations regarding the use of the card as outlined in the cardholder agreement to which you agree to be bound.

³ Direct Deposit

The reimbursement method is either check or direct deposit. Direct deposit is a faster and safer means of reimbursement. The initial direct deposit may take up to 10 days, but subsequent direct deposits normally take 2 business days from the date of initiation. Bank holidays and weekends may affect when your direct deposit is credited to your account. Please contact your bank to verify that an expected deposit was received. If you elect to be reimbursed by check, there is a \$25 fee to reissue lost/stolen checks.

Qualifying Medical Care and Dependent Care Expenses

I understand that reimbursement will be available only for "qualifying medical care expenses" as listed under Section 213 and "qualifying dependent care expenses" as listed under Sections 129 and 21 of the Internal Revenue Code for me and my eligible dependents. These expenses must be incurred while I am enrolled in the Plan. I agree to notify the Plan Sponsor or Planned Benefit Systems, Inc. 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 for which I have been reimbursed that is not allowed under IRC Sections 213, 129 or 21. This includes purchases made with the *MBI Benefits Card*. I attest that I understand that 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. I acknowledge that the claimed 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 Planned Benefit Systems, Inc. for claims substantiation as required.

Participation Rules

I understand that reimbursement account eligibility, enrollment, and benefits information is available from my Plan Sponsor. I authorize payroll deductions for the benefits elected on this form. I understand that I cannot change or revoke this compensation reduction agreement at any time during the Plan Year except for the occurrence of a Change in Status (including marriage, divorce, death, birth or adoption of a child, change or termination of spouse's employment, change in dependent care provider or such other events as the Plan Sponsor determines will permit a change or revocation of an election). In case of a Change in Status, I must complete a Change Form no later than 30 days after the date of such change if I want to enroll in a reimbursement account or 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. Expenses incurred prior to my plan enrollment date are not eligible for reimbursement.

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 in effect; 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).