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Interactive Medical Systems

FLEXIBLE BENEFITS ENROLLMENT FORM

Company Name _____ Plan Effective Date _____

Employee Name _____
First Middle Last

Address _____

_____
City State Zip

Social Security Number _____ Dept. Number _____

authorizes my employer to reduce my salary by the amount(s) necessary to cover my participation in my company's Flexible Benefits Program as selected below.

Dollar amounts given are: weekly ☐ bi-weekly ☐ semi-monthly ☐ monthly ☐
annual ☐ other ☐ (please explain)

Reimbursement Account for Non-Covered Health Care Expenses
This includes deductible, co-insurance, eye care, dental care, prescription birth control, routine care, well-baby care, etc. $_____

Reimbursement Account for Dependent Day Care
(Maximum yearly amount is $5,000 for married individuals filing jointly and single individuals or $2,500 for married individuals filing separately.) $_____

Total $ 0.00

My Employer's benefits have been explained to me and I understand that:

1. I can NOT change or revoke my election UNLESS I have a change in family status (marriage, divorce, death or a spouse or child, birth or adoption of a child, or termination of a spouse's employment).
2. Should the rates for a specific benefit be increased, my employer may increase my participation amount.
3. The total amount deducted for the Reimbursement Accounts must be used during the Plan Year or forfeited under IRS rules.
4. Participation in the Flexible Benefits Plan may mean that I will be paying less Social Security Tax, which could slightly reduce my Social Security benefits when I retire.

I authorize my Employer to reduce my salary by the amount of o my insurance premiums if I have elected this option and by the amounts shown above.

_____
Signature Date