BAY COUNTY FLEXIBLE BENEFITS PLAN (125 Cafe)
ELECTION FORM AND COMPENSATION REDIRECTION AGREEMENT
Plan Year: Jan. 1, 2017 – December 31, 2017

Employee's Name: _____ Social Security Number: _____

Employee's Address: _____ City, ST, Zip _____

Employee's Date of Birth: _____ Debit Card (Please Circle One) Yes No Extra Card Name _____

As an eligible participant in the Flexible Benefits Plan, I understand the benefits available to me as well as the other rights and obligations I have under the plan. In accordance with my rights under the Plan, I elect the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the plan year; (Or during such portion of the year as remains after the date of this agreement).

ELECTION OF BENEFITS

CODE	EMPLOYEE ELECTIONS		Per Month Amount		Per Pay Period
Employer	Use Only	Health/Life	CAFÉ	Non-CAFÉ	CAFÉ
		Group Health	$	N/A	N/A
		Group Life Ins (Basic $10,000)	$	N/A	N/A
		Flexible Benefits			
0350		Health Care Reimbursement (FSA) **(Max $2550 p/year)**	N/A	N/A	$
		Health Savings Account (HSA) High Deductible Plan Only*	N/A	N/A	$
0330		Dependent Care Assistance **(Max $5000 p/year)**	N/A	N/A	$
		Employee Options			
		Group Dental	$	$	N/A
		Supplemental Life Insurance	$	$	N/A
		Group Vision Insurance	$	$	N/A
		AFLAC	$	$	N/A
		Liberty Life	$	$	N/A
		American Heritage	$	$	N/A
		Disability Insurance (non-tax only)	N/A		N/A

EO=Employee Only
Code 3-HIGH (Plan 3160=1300 Deductible/No co -pay) **E+SP= Employee + Spouse**
Code 3-HIGH (Plan 3161=2600 Deductible/No co -pay) **E+Ch= Employee + Children**
HSA/EMPLOYEE ONLY: 3400.00 MAX Contribution p/yr
HSA/FAM: 6750.00 Max contribution p/yr* ****HSA age 55+ add $1000 for eligible individuals**

INSURANCE BENEFITS

I understand that:
-If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

HEALTH CARE REIMBURSEMENT AND/OR DEPENDENT CARE ASSISTANCE BENEFITS

I understand that:
-Reimbursement will be available only for "qualifying health care expenses" and/or "qualifying dependent care expenses" as described in the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer, on demand, for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
-This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.

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OTHER TERMS AND CONDITIONS

I understand that:

-Prior to the first day of each plan year I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit coverage and amount of compensation redirection then in effect for the new plan year for insured benefits only.

-I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse) or such other events as the Plan Administrator determines will permit a change or revocation of an election.

-The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

-The redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements or benefit plans.

-The amount of my compensation redirection will be credited to an insurance, health care reimbursement, and/or dependent care assistance account(s). Such amount(s) will be paid on my behalf or I will be reimbursed, up to the balance in that account for qualifying dependent care expenses and/or up to my annual election amount for qualifying unreimbursed medical expenses, for the applicable expenses incurred during the year.

-Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year.

-My social security benefits and TSA contributions may be slightly reduced as a result of my election.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S FLEXIBLE BENEFITS PLAN, HEALTH CARE REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PROGRAM 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 REDIRECTION AGREEMENT RELATING TO SUCH PLAN(S).

Employee's Signature:_____ **Date:**_____

-OFFICE USE ONLY-

Accepted and agreed to by the Employer's Authorized Representative.

By:_____ Date:_____

Payroll Deductions Will Begin On Check Date:_____