CAFETERIA PLAN ELECTION FORM

(Please clearly print all information)

E**mployer Name: TALMUDICAL ACADEMY OF BALTIMORE, INC Plan Year: 10/01/2018 – 9/30/2019**

Participant Name: _____ Social Security Number: _____

Address: _____Date of Birth: _____

City, State, Zip: _____ Phone Number: _____

E-Mail Address: _____

New Hire_____ Open Enrollment_____ Change in Status_____ (please provide explanation below)

Status Change Reason _____

FLEXIBLE SPENDING ACCOUNT (FSA) *please choose correct number of pay periods*
****dental & vision expenses only****

I elect to participate. Yes_____ No_____

(Not to exceed limit $2650)

$ _____ per pay x **20** pay periods = $ _____Annually ***(do not round)***

$ _____ per pay x **24** pay periods = $ _____Annually ***(do not round)***

EMPLOYER MUST COMPLETE FOR MID YEAR ENROLLMENTS

Date of 1st deduction _____
Eligibility date _____

DEPENDENT CARE ACCOUNT (DCAP) – Day Care Expenses *please choose correct number of pay periods*

I elect to participate. Yes_____ No_____

(Not to exceed $5,000, or $2,500 if married and filing separately)

$ _____ per pay x **20** pay periods = $ _____ Annually ***(do not round)***

$ _____ per pay x **24** pay periods = $ _____Annually ***(do not round)***

I request that my periodic paychecks for the plan year be reduced on a pro rate, pre-tax basis by the sum of my medical reimbursement, dependent care, and health care premium to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

Complete and return to your benefits coordinator.

601 VISIONS PARKWAY ADEL, IOWA 50003
PHONE: 800-309-8012 Fax: 515-993-5033
www.baseonline.com

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By: ____ Date: _____

Rev: 01/06/09