Bene-Flex Hawaii, Inc. ***Cafeteria Plan Administrators***

Cafeteria Plan Election/Compensation Reduction Agreement For:

_____ Plan Year Election: _____
Employer's Name

Please Check **ONLY ONE**: _____Initial Enrollment _____Re-enrollment _____Status change
*Status Change must be accompanied by documentation relating to the "Status Change". Effective Date: _____

YOUR NAME:_____
(**Please PRINT clearly**):**Last Name** **First Name** **MI**

Mailing Address_____ Social Security # _____-____-_____
_____ **Would you like to have Direct deposit**
Email address_____ **of your reimbursements? ____ Yes _____ No**

YOUR CAFETERIA PLAN ELECTIONS:

I DO NOT WISH TO PARTICIPATE _____ (Initial here if you do not want to participate)

Please Check **YES** or **NO** to tell us what benefits you are electing for this Plan Year. Please also enter the amount you elect to contribute to each eligible benefit you have elected.

LIST AMT. PER MONTH

MEDICAL/DENTAL **INSURANCE PREMIUMS** _____YES _____NO AMT. _____

OTHER INSURANCE PRODUCTS: _____YES _____NO (List Product & amt)
_____ AMT._____
_____ AMT._____
_____ AMT._____

MEDICAL/DENTAL/DRUG/VISION REIMB. _____YES _____NO AMT._____

DEPENDENT/CHILD CARE REIMB. _____YES _____NO AMT._____

I understand that my Employer makes no guarantee that any benefits I elect under this Plan will be excludable from my gross income for Federal and State income tax purposes**. I hereby authorize my Employer to reduce my gross payroll by the amounts indicated above.**
I understand that to participate I must complete a new Election/Compensation Reduction Agreement each plan year. Participation is **NOT** automatic.
I understand the contribution to my Social Security account may be reduced and may affect my Social Security benefits at retirement and/or disability.
I understand that any amount remaining in either spending/reimbursement account that is not used during the plan year will be **forfeited** since the IRS regulations state that the money cannot be carried forward to the next plan year or returned to me.
I understand that the funds in the account can only be paid out to reimburse payment of allowable expenses actually incurred during the plan year while I am actively participating in the program.
I understand that my election is irrevocable for the plan year, unless I have an allowable status change, and I agree to notify Bene-Flex Hawaii, Inc. of any status change within 90 days of the status change in writing.
Following any unpaid leave of absence, I understand that I will be required to "catch up" on any missed Medical Expense Plan deductions while on leave.
I also agree to have my share, if any, of the participation fee listed on the Election Information sheet deducted from my payroll on an after-tax basis.

Employee Signature:_____Date:_____

White Copy: Bene-Flex Hawaii, Inc. Yellow Copy: Employer Pink Copy: Employee

Instructions for Completing the Compensation Reduction Agreement

Employee Information – Completely fill in all of your personal data.

Product Information- Complete this section if you are electing Insurance products

Dependent Care Spending Account – Complete only if you wish to enroll in the Dependent Care Spending Account

Medical Spending Account – Complete only if you wish to enroll in the Medical Spending Account.

Employee Signature – Sign and date this section.

Return the completed white & yellow copies of this form to: Bene-Flex Hawaii, Inc. , P.O. Box 428 Kailua, Hawaii 96734 or your Payroll department. Keep the pink copy for yourself.

Plan Highlights

I understand that with the **Dependent Care Spending Account**:

- Dependent care expenses are reimbursable if my spouse (if I am married) and I are both employed or if my spouse is a full-time student.
- I may not claim for services for periods I (or my spouse if I am married) did not work or while not on duty, (e.g., leaves of absence, vacation, sick leave, etc.).
- Dependent care expenses must be for my dependent child under age 13 or other dependents (e.g., a physically or mentally handicapped relative or other person living in my home who is unable to care for himself/herself and over half of whose support I pay).
- I can contribute up to $5,000 per year if I am a single parent, or married and filing a joint return. This maximum is the total family contribution allowable and must include the annual administration fee. My maximum may be lower if:
  - I or my spouse earns less than $5,000,
  - My spouse is a full-time student or incapable of self-care, or
  - I am married, but file a separate federal tax return.

  If any of the above exceptions apply, please call Bene-Flex Hawaii, Inc. at 254-9166 or toll free at 1-877-760-9898.
- Care cannot be provided by my spouse or anyone I claim as a tax dependent.
- I cannot claim as a tax credit the same dependent care expenses that are reimbursed under this plan.
- My claims will be reimbursed for the amount of my eligible "out-of-pocket" expenses up to the amount in my account balance after service has been rendered.
- I will be required to identify the person or agency performing the child care services to the IRS by providing his/her federal I.D. number or social security number.

I understand that with the **Medical Spending Account**:

- Health-related expenses are reimbursable if they can be considered "deductible" medical expenses on my tax return as defined under section 213(d) of the Internal Revenue Code ("IRC"). Certain insurance premiums and unnecessary cosmetic surgery are examples of ineligible expenses. See, IRS Publication 502 for guidelines. I cannot claim on my tax return the same health care expenses that are reimbursed under this plan.
- The maximum I may contribute is determined by your employer per plan year, plus any administration fee if applicable. If both my spouse and I are eligible for the Cafeteria Plan Medical Spending Account, we may each contribute up to your employer's annual maximum per year.
- My claims will be reimbursed for the amount of my eligible "out-of-pocket" expenses up to my annual election, minus previous claims paid.
- I may be eligible to continue in the Medical Spending Account on an after-tax basis through COBRA if a qualifying event occurs, such as separation from service.

I understand that with the **Dependent Care** and **Medical Spending Accounts:**

- My election is **irrevocable** for the plan year, unless I have an allowable status change. Examples of allowable status changes include, but are not limited to: changes in legal marital status, changes in the number of dependents, and changes in employment status.
- The election change must be consistent with the status change and may be made only after Bene-Flex Hawaii, Inc.'s receipt and approval of the required status change.
- I must submit a change in status to Bene-Flex Hawaii, inc. 90 days of the status change event. Otherwise, my election cannot be changed.
- I will have 90 days following the end of the plan year to file claims for expenses incurred during the plan year.
- You must accumulate your claim total to at least $25 before reimbursement will be made, except that at the end of the plan year, amounts less than $25 will be reimbursed.
- All receipts must contain **complete** information before my reimbursement can be processed, and this should be submitted before the 90th day after the end of the current plan year. Otherwise, corrected claim forms received after that date shall not be reimbursed.
- I may be required to pay a monthly administration fee to participate. Whether I participate in one or both flexible spending accounts there will be one monthly fee. You may call Bene-Flex Hawaii, Inc. for the current administration fee.
- Any money left in my account after the 90th day after the end of the plan year, (after I have claimed all eligible expenses for that year), will not be reimbursed to me and will be **forfeited** to your employer pursuant to the IRC. The IRS considers the date of a claim as the date the service is rendered, not when the bill is actually paid.

For more information on the Plan, please read the Bene-Flex Hawaii, Inc.'s employee informational booklet, or call Bene-Flex Hawaii, Inc.