ERGON

FSA Election Menu

Please return this form to hr@ergon.com or to P.O. Box 1639, Jackson, MS 39215

Company Name Ergon and Its Subsidiaries **Effective Date** January 1, 2023

Employee Name: _____ **Social Security Number:** _____

Street Address: _____ **City, State, ZIP:** _____

Date of Birth: _____ **Office Location:** _____

SPENDING ACCOUNTS	Annual Election	
Medical Reimbursement	$ _____	*($3,050 is maximum amount)*
Dependent Care Reimbursement	$ _____	*($5,000 is maximum amount)*

Medical Care Reimbursement
I understand that: a) Expenses cannot be claimed if paid by any other health plan; b) I must submit a Reimbursement Claim itemizing the expenses to be reimbursed and include supporting evidence as set forth in the Plan; c) Expenses must be incurred within the Plan Year, regardless of when I actually pay the expense.

Dependent Care Reimbursement
I understand that: a) Child must be under 13 years of age; b) Cannot be claimed on Federal Income Taxes if claimed under Flex Plan; c) Must be necessary in order to work; d) The tax savings derived by including dependent care expenses in this Plan should be compared to the tax credit allowed on my income tax return; e) File Form 2441.

PARTICIPATION AGREEMENT
I understand that selection of new insurance coverage does not automatically provide coverage and I must complete an application for insurance. I understand that any election made under the Cafeteria Plan herein is irrevocable and may only be changed at enrollment prior to the start of the new Plan Year, or in the event of a change in family status (i.e., change in marital or dependent status, death of employee's spouse, or dependent, or a spouse's change in employment status).

- I cannot change or revoke this agreement prior to the first day of the next plan year, except as permitted by the Plan and/or the Internal Revenue Code.
- The Plan Administrator may modify or cancel the amount of my salary reduction under this Agreement, if necessary, to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this Agreement will be in addition to pay reductions under other agreements or benefit plans.
- Benefits under the Plan may be reduced or cancelled by the Employer at any time.

I also understand that if changes in premiums are not made at enrollment, I will be treated as having continued the same elections in effect for subsequent plan years. At enrollment, elections must be made in the Spending Accounts or they will be terminated. I am aware that any expenses paid through the Cafeteria Plan are no longer eligible as deductions for federal or state income tax purposes and participation may reduce my future Social Security entitlement.

I hereby agree my cash compensation will be reduced per pay period by my annual election during the Plan Year. Prior to December 1 each year, I will be offered the opportunity to change my election.

I understand that if I do not claim the total balance in my Spending Accounts within 60 days (last day of February of each year) after the Plan Year ends as set forth in the Plan Document, I will forfeit my right to the remaining balance in the Dependent Care Flexible Spending account, and up to $610 of the unused amount in the Medical Flexible Spending Account for a Plan Year may be rolled over for use in the entire, subsequent Plan Year.

Signature: _____ Date: _____

WAIVER OF PARTICIPATION
I understand that all benefit coverages now offered by the above-mentioned employer through payroll deduction are available to me under the above-mentioned employer's Cafeteria Plan and that the intent of Plan participation is to reduce the cost of these benefit coverages to me. I have been offered the opportunity to participate in this Plan and do hereby decline this opportunity and elect to receive current compensation. I understand if changes are not made at enrollment, I will be treated as having continued to waive my participation for subsequent plan years.

Signature: _____ Date: _____