Employee Benefit Concepts, Inc.
a Group Resources Company
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Section 125 Enrollment Form

❒ Amended Form
❒ Original Enrollment Form

EASTPOINTE COMMUNITY SCHOOLS		EMPLOYEE INFORMATION FLEXIBLE SPENDING ACCOUNT(S)	
Employee Name:		**Plan Year:**	**January 1, 2022 - December 31, 2022**
Address:		**Hire Date:**	
City, State, Zip:		**Effective Date:**	
Home/Cell Phone:		**First Pay Date:**	
Birth Date:		**Number of Pays:**	
Employee SS #:		***Debit Card**	**YES OR NO**
Email Address:		**Additional Card Name**	

As an eligible participant in the Cafeteria Plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

In accordance with my rights under the Plan, I elect the following benefits and designate 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 Insured Benefits

On the appropriate benefit enrollment form (s), I have enrolled for certain Insured 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.
- Prior to the first date 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 either continue my benefit coverage and amount of compensation redirection (then in effect) for the new plan year, or to have elected not to participate for the upcoming plan year, as set forth in the Summary Plan Description.

Election of Health Care Reimbursements

FSA: I elect to receive health care reimbursements for the plan year. Amount of compensation redirection: $_____ per each pay period which is a total of $_____ for the plan year **(maximum cannot exceed $2,850.00 per plan year).**

Dental Buy Up: (Employer Funded) $_____

I understand that:

- Reimbursement will be available only for "qualifying health 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 the redirection.

Election of Dependent Care Assistance

DCA: I elect to receive dependent care assistance for the plan year. Amount of compensation redirection: $_____ per each pay period which is a total of: $_____ for the plan year **(maximum cannot exceed $5,000).**

I understand that:

- Reimbursement will be available only for "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 the redirection.

Other Terms and Conditions

I understand that:

- 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 or commencement 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 and such amount will be paid on my behalf or I will be reimbursed, up to the amount which I have elected to redirect to the Cafeteria Plan, 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 may be slightly reduced as a result of my election.
- I hereby consent to the use of my personally identifiable information, and or my dependent (s)' information, which I have voluntarily provided in this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, or my dependent (s)' behalf, for the sole use of providing benefits, services, or any information I have requested.

I hereby authorize the Employer to withhold a service fee of $_____ per pay period from my compensation for administrative costs of the plan.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, HEALTH CARE REIMBURSEMENT PLAN AND/OR DEPENDENT CARE ASSISTANCE PLAN (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).

This agreement is subject to the terms of the Eastpointe Community Schools Flexible Compensation Plan, as amended from time to time, and revokes any prior election and compensation reduction agreement relating to such plan.

_____ **Date** _____

Employee Signature

_____ **Date**_____

Employer Signature

Waiver of Participation

This waiver will acknowledge that I have been informed of the terms of the above referenced Plan. Even though I am eligible to participate in such Plan, I hereby elect not to participate. I understand that this waiver will remain in effect for the remainder of the plan year for which this election is effective, but that I may again decide to participate in later plan years by making an election to participate during the election period prior to each plan year.

This waiver is effective for the plan year running from January 1, 2022 to December 31, 2022.

Employee's Signature: _____ Date: _____

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

By: _____ Date: _____

PLEASE SUBMIT ORIGINAL FORM TO ADMINISTRATIVE SERVICES / BENEFITS