AXISPLUS BENEFITS

BENEFIT ELECTION FORM

EMPLOYEE INFORMATION

NAME (FIRST, MIDDLE, LAST):			DATE OF BIRTH (MM/DD/YYYY):
SOCIAL SECURITY NUMBER:	EMPLOYER NAME: Nebo School District		
EMPLOYEE HOME ADDRESS:	CITY:	STATE:	ZIP CODE:
E-MAIL ADDRESS:	HIRE DATE(NEW EMPLOYEES ONLY):		

PLEASE LIST DEPENDENT INFORMATION (Please attach a separate sheet for additional dependents)

SPOUSE NAME:	BIRTHDATE:	DEPENDENT (1):	BIRTHDATE:
DEPENDENT (2):	BIRTHDATE:	DEPENDENT (3):	BIRTHDATE:

FSA PAYROLL DEDUCTION

MEDICAL/HEALTH CARE FSA ELECTION

	Employee and dependent's out-of-pocket medical, dental and vision expenses. *$3050 annual maximum per participant*	PER PAY PERIOD	$
		TOTAL ANNUAL ELECTION	$
>	**CHECK HERE IF PARTICIPATING IN AN HSA. MEDICAL FSA WILL BE LIMITED PURPOSE, COVERING DENTAL AND VISION EXPENSES ONLY.** ☐		

DEPENDENT CARE FSA ELECTION

	Child or dependent care expenses (ex. day care) *$5000 annual maximum for single and married filing jointly, $2500 annual maximum for married filing separately.*	PER PAY PERIOD	$
		TOTAL ANNUAL ELECTION	$

TOTAL ANNUAL CONTRIBUTION $

REIMBURSEMENT METHOD

> **CONTACT YOUR EMPLOYER FOR AVAILABILITY. IF LEFT BLANK, REIMBURSEMENT CHECKS WILL BE ISSUED.**

☐ AxisPlus Debit Card (Please print clearly.) (Medical/Health Care FSA only - no Limited Purpose FSA)

NAME ON CARD:

AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that pretax deductions to my Health and/or Dependent Care FSA can only be used to reimburse eligible expenses and that any remaining funds at the end of the plan year will be forfeited. This election form will remain in effect and cannot be revoked or changed during the plan year, unless consistent with the qualifying events allowed under this Plan. I have read the Summary Plan Description (SPD) provided to me by my employer. I authorize payroll reductions as contributions to my Flexible Spending Accounts and/or Premium Only Account as indicated above. Please see your employer or HR contact for administration fee rates, if applicable.

If elected, you will receive an AxisPlus Visa debit card, and agree to use it according to the Cardholder Agreement that will be provided to you with the Card. You understand that the Card is to be used exclusively for qualified expenses as defined by the plan(s) in which you participate. If the card is used for non-qualified expenses, you are indebted to your employer and must repay the full ineligible amount. You agree to save all supporting documentation for payments made with the Card and to provide copies of that documentation to AxisPlus Benefits upon request. Failure to do so will cause the payment to be treated as a non-qualified expense.

TO AUTHORIZE PARTICIPATION:

I hereby certify the above information to be correct and true and choose to participate.

SIGNATURE: DATE:

Please see reverse side to decline participation.

TO DECLINE PARTICIPATION:

The benefits of the plan have been thoroughly explained to me, but I choose not to participate.

Signature Date