



The Gold Standard
in Benefit Services

Please fax, email, or mail to:
Goldleaf Partners
Flexible Spending
PO Box 806
Brainerd, MN 56401

Email: benefits@goldleafpartners.com
Phone: (866)882-8442
Fax: (480) 782-1842

ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT

Church/Employer Name _____

Employee Name _____

Employee Address _____ City, State, Zip _____

Employee Social Security # _____ Daytime Phone _____

Plan Year _____ Effective Date _____

Date of Birth _____ Email Address _____

As an eligible employee in the above 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 for the Plan Year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each pay period and Plan Year (or during such portion of the year as remains after the date of this agreement). My signature also validates that I agree to the conditions on this form.

ELECTION OF PRE-TAX BENEFITS UNDER THE SALARY REDUCTION PLAN

I elect to receive the following coverage's under the Plan. I understand that the amount equal to the annual contributions for the benefit options I have elected, divided by the number of pay periods in the Plan Year, will be deducted on a pre-tax basis from each of my paychecks to pay for coverage that I elect. (Check all boxes that apply)

Pre-Tax Premium Payment Benefits (for group insurance):

- On separate benefit enrollment form(s), I have enrolled for Medical/Dental Insurance coverage and I have received a schedule showing my share of the contributions for such coverage.

Outside Individual Insurance Premiums : I understand that I must furnish adequate proof of this coverage and payments made.

- I elect to contribute \$ _____/year \$ _____/per pay

Health Flexible Spending Accounts (FSA) Benefits: If you are interested in an HSA-compatible FSA (vision & dental only), please contact the administrator. (Annual maximum is \$5000 per calendar year).

- I elect to contribute to a **General –Purpose Health FSA:** \$ _____/year \$ _____/per pay

Dependent Care Benefits: (Annual maximum is \$5,000 per household per calendar year).

- I elect to contribute: \$ _____/year \$ _____/per pay

Goldleaf Partners OneCard:

- Yes, I want the OneCard and understand that it is to be used only for eligible medical expenses for myself and/or any of my Federal Tax Dependents. I also must save all itemized receipts from card transactions. Please note existing cards remain active across plan years until deactivated due to termination or expiration date on card commences.

____ I need a new or replacement Goldleaf OneCard (\$10.00 charge for replacement cards).

____ I would like to order a card for my dependent (\$1.50 charge per dependent card; \$10.00 charge for replacement card).

Name _____ Relationship _____ Social Security Number _____



Dependent Information

Spouse Son Daughter Other tax dependent _____

Name (Last, First, Middle)	Social Security Number (Last 4 Digits)	Date of Birth
Street Address (only if different)	City, State, Zip	

Son Daughter Other tax dependent _____

Name (Last, First, Middle)	Social Security Number (Last 4 Digits)	Date of Birth
Street Address (only if different)	City, State, Zip	

Son Daughter Other tax dependent _____

Name (Last, First, Middle)	Social Security Number (Last 4 Digits)	Date of Birth
Street Address (only if different)	City, State, Zip	

Son Daughter Other tax dependent _____

Name (Last, First, Middle)	Social Security Number (Last 4 Digits)	Date of Birth
Street Address (only if different)	City, State, Zip	

Son Daughter Other tax dependent _____

Name (Last, First, Middle)	Social Security Number (Last 4 Digits)	Date of Birth
Street Address (only if different)	City, State, Zip	

Son Daughter Other tax dependent _____

Name (Last, First, Middle)	Social Security Number (Last 4 Digits)	Date of Birth
Street Address (only if different)	City, State, Zip	

Waiver of Pre-Tax Benefits Under the Salary Reduction Plan: Election of After-Tax Benefits

(Check box if applicable; do not check this box if you have checked one or more boxes in the section above.)

I elect to waive all pre-tax benefits under the Plan. I understand that if I have enrolled for medical insurance coverage on a separate benefit enrollment form, I will pay my share of the contribution with after-tax payroll deductions. Except for a Change in Election Event for the applicable Benefits, I understand that I cannot elect pre-tax benefits until the next Open Enrollment Period, and any after-tax coverage's shall be outside of the plan.

Employee's Signature

Date

Accepted and agreed to by:

Employer's Authorized Representative Signature

Date



I understand that:

Reimbursements will be available only for "qualifying medical care expenses" and "qualifying dependent care expenses" for yourself, your spouse and tax dependents. Generally, "qualifying expenses" are those expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation) or otherwise allowed by law. 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. 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 specifically for me in a later Plan Year.

Claims must be submitted within 90 days after the end of the Plan Year.

If I cease my employment with the Employer, my participation in the Health Flexible Spending Account may be subject to the continuation coverage rules of COBRA.

I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction or credit on my tax return, or that I have been reimbursed from any other source.

Women's Health and Cancer Rights: This plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema). Contact your Plan Administrator for more information.

I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense, services rendered, date of service, and patient's name as proof that the expense has been incurred.

I agree to provide the Administrator with the name, address, and if applicable, the taxpayer identification number of the service provider.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year.

I will only be reimbursed for amounts up to the balance in my account at the time of my request for Dependent Care and Outside premium reimbursement plans.

I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this Dependent Care Flexible Spending Account.

If I participate in a Health Savings Account, I may only seek reimbursement for dental and/or vision expenses through the Health Flexible Spending Account.

I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan Year unless I have a change in family status and my election is consistent with such change. The Health Savings Account election may be changed at least monthly.

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

If I select to be covered under the disability insurance through the Plan, then any benefits paid to me from such insurance will be fully taxable to me and that it will be my responsibility to include these amounts in my gross income.

Prior to the first day of each Plan Year I will be offered the opportunity to change my benefit elections 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 not to participate for the following Plan Year.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA 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 REDUCTION AGREEMENT RELATING TO SUCH PLAN.

