

**City of Idaho Falls
Sec. 125 Cafeteria Plan
Salary Reduction Agreement for 2016 - 2017 Plan Year**

Employee Name (Last, First, MI) <i>Please Print</i>	Home Phone Number
Employee Street Address	City State Zip Code
Date of Birth	Social Security Number
E-mail address	Mother's Maiden Name (Security Purposes Only)
Print Name as it will appear on 1 st Card (21 characters maximum)	Print Name as it will appear on 2 nd Card (optional) (21 characters max)

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the plan effective date shown above. I further authorize future adjustments in the amount of my salary reduction if the carrier changes the cost of coverage in any program selected below during the plan year. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed. Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by entering the total per pay period cost and the total amount paid by the pre-tax reduction or after-tax deduction.

Reimbursement Plans

Please list your yearly election by completing the table below:

	Per Pay Period Deduction	Number of Pay Periods Remaining During Plan Year	Total Annual Amount Elected
General Purpose FSA	_____ X	26	= \$
*Dependent Care Assistance Plan	_____ X	26	= \$
TOTAL DEDUCTIONS			= \$

***Cards will not be issued for the Dependent Care Assistance Plan. I understand that there is an administrative fee of \$4.00 per month that is due to our Third Party Administrator of which will be deducted monthly from my paycheck for a total annual deduction of \$36.00**

ALL FLEX CLAIMS MUST BE INCURRED BY SEPTEMBER 30TH OF EACH PLAN YEAR.
ALL REQUESTS FOR REIMBURSEMENT MUST BE SUBMITTED BY DECEMBER 29TH OF THE SAME YEAR.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in status event as listed on the Status Change Matrix available with the summary plan description. If I experience a qualifying event, I understand I must notify Human Resources within 30 days. I understand that the cards are available for medical expenses only.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate**.

Signature _____ Date _____

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate**.

Signature _____ Date _____

mySourceCard™ Enrollment Agreement

As a participant in one or more of the Reimbursement Plans indicated on this form, you will be issued a mySourceCard™ MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to the terms of this Agreement and the Cardholder Agreement that will be provided to you with the Card. You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank, or ATM. 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 issued pursuant to a Reimbursement Plan as indicated on this form and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-Qualified Expense. You agree to save all invoices and receipts related to any expense paid with the Card and upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-Qualified Expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, personal check or ACH draft, or a deduction from your paycheck.