TerrillFLEX

Drury University
Flexible Benefit Plan
Election Form

Plan Year 01/01/2020 - 12/31/2020

PAY PERIODS

[ ] Semi-Monthly (12 Pay Periods)

EMPLOYEE INFORMATION

Employee Name: Social Security #:

Address: City, State, Zip Code:

Email Address:

DEPENDENT INFORMATION

Please complete for your spouse/dependent to receive a debit card.

Dependent Name: Social Security #:

Address: City, State, Zip:

Relationship: Full-Time Student: Yes or No

MEDICAL/DENTAL/VISION INSURANCE

[ ] I hereby make my elction for the Flexible Benefit Plan.
with premium payment made on a **pre-tax** basis.

	For Personnel Use Only Per Pay Period
MEDICAL REIMBURSEMENT ACCOUNT [ ] Estimated qualifying health care expenses for you and your dependents. ($2,700 max) Amount $_____ x 12 of Payperiods = $_____ Annual Election	$ _____
DEPENDENT CARE REIMBURSEMENT ACCOUNT [ ] Estimated qualifying dependent care expenses. ($5,000 max) Amount $_____ x 12 of Payperiods = $_____ Annual Election	$ _____
TOTAL OF ELECTIONS:	$ _____

WAIVER OF PARTICIPATION

[ ] After careful consideration, I have chosen not to participate in the Flexible Benefit Reimbursement Plan for the current Plan Year. I understand that I can elect to participate in subsequent Plan Years.

_____ _____

Employee Signature **Date**

[ ] I hereby make my election for the Flexible Benefit Plan ending December 31, 2020.

I understand that this election is irrevocable during the Plan Year except in the case of a change in family status and if I contribute more to the Medical Care and/or Dependent Care Spending Accounts than I can claim in expenses for qualifying services rendered or products received during the PLAN year, I WILL FORFEIT THE EXCESS AMOUNT for the Dependent Care Account. Amounts up to $500 that remain in the Medical Care Spending Account after payment of all timely presented claims for the Benefit for expenses incurred during the Plan Year shall be carried over for use during the next Plan Year. Any amount in excess of $500 remaining in a Medical Care Spending Account after payment of claims for the applicable Period of Coverage shall be forfeited.

I understand that I will use the Flex Convenience Card for eligible medical care expenses and dependent care reimbursement where the flex card is honored or accepted. Each time I use the card, I reaffirm the certification that any expense paid with the card has not been reimbursed and I will not seek reimbursement under any other plan covering health benefits.

I agree to acquire and keep sufficient documentation (e.g., invoices and receipts) for expenses paid with the card.

_____ _____

Employee Signature (REQUIRED) **Date**

FOR PERSONNEL USE ONLY

Effective date of election:_____ **First payroll deduction date:**_____