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MESSA OptionALL

Medical/Dependent Care Flexible Spending Account

ELECTION AND SALARY REDUCTION AGREEMENT FORM

Employee name _____
First *Middle* *Last*

Address _____
Street *Apt. / lot #*

_____
City *State* *Zip code*

Social security number _____ Gender ☐ male ☐ female

Job title _____ Date of birth _____

Employer _____

Daytime telephone number _____

BENEFIT ELECTION

I am electing the following benefits:

ANNUAL EMPLOYEE CONTRIBUTION

☐ Dependent Care Reimbursement Plan **($5,000 max)*** $ _____

☐ Medical Reimbursement Plan **($2,750 max)**** $ _____

Number of pay periods _____ First payroll deduction date _____

*See plan document for IRS allowed amounts.
****NOTE**: If your plan includes carryover, and you have 2019 funds remaining, you must re-enroll in the 2020 FSA to utilze those funds, even if it is a $0 election amount.

I understand that this election will remain in effect in accordance with the rules and procedures of the MESSA OptionALL plan. I MUST complete a new Benefit Election form each plan year.

_____ _____
Employee signature Date