BAY COUNTY FLEXIBLE BENEFITS PLAN (125 Cafe)
ELECTION FORM AND COMPENSATION REDIRECTION AGREEMENT
Plan Year: Jan. 1, 2021 – December 31, 2021

Employee Name:		**SSN:**		**Date of Birth:**	
Address:		**City, ST, Zip:**			
Debit Card:	☐ **Yes** ☐ **No**	**Addt'l Card Information (Name):**			

As an eligible participant in the Flexible Benefits Plan, I understand the benefits available to me as well as the other rights and obligations I have under the plan. In accordance with my rights under the Plan, I elect the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the plan year; (Or during such portion of the year as remains after the date of this agreement).

ELECTION OF BENEFITS

COVERAGE	OPTION	EMPLOYEE ELECTIONS	Per Month Amount		Per Pay Period
		Health/Life	CAFÉ	Non-CAFÉ	CAFÉ
Decline	☐ **3160** ☐ **3161**	Group Health **03160 Hi Deductible / $1400** **03161 Hi Deductible / $2800**	$		
$	County Paid	Group Life **1x Salary up to $50,000**			
		Flexible Benefits			
	0350	Health Care Reimbursement (FSA) **(Max $2750/yr.)**			$
		Health Savings Account (HSA)* **Employee Only: $3600/yr. Family: $7200/yr.**			$
	0330	Dependent Care Assistance **(Max $5000/yr.)**			$
		Employee Options			
Decline	Decline	Group Dental	$	$	
		Supplemental Life Ins. (Café max $50K)	$	$	
Decline		Group Vision Insurance	$	$	
		Disability Insurance (Non-Cafe only)		$	
		AFLAC	$	$	
		Liberty Life	$	$	
		Cincinnati Life		$	
		457 Plan/Deferred Comp.			$
		Other	$	$	$

I understand that-if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease, and reimbursement will be available only for "qualifying health care expenses" and/or "qualifying dependent care expenses" as described in the Summary Plan Description. 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. This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.
I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse) or such other events as the Plan Administrator determines will permit a change or revocation of an election.
-My social security benefits and TSA contributions may be slightly reduced as a result of my election.

This agreement is subject to the terms of the employer's Flexible Benefits Plan, Health Care Reimbursement Plan, and/or Dependent Care Assistance Program 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 redirection agreement relating to such plan(s).

Employee's Signature:_____ **Date:**_____

OFFICE USE ONLY: Accepted and agreed to by the Employer's Authorized Representative

By:		**Date:**		**Date Payroll Deductions Begin:**	