

FLEXIBLE SPENDING ACCOUNT SECTION 125 FSA ENROLLMENT FORM  
OKLAHOMA ANNUAL CONFERENCE, THE UNITED METHODIST CHURCH FLEXIBLE BENEFIT PLAN

ELECTION PERIOD: From \_\_\_\_\_/\_\_\_\_\_/2011 Through 12/31/2011

**please print**

NAME OF ELIGIBLE PARTICIPANT (Last) (First) (Middle)	Church Phone Number:
Social Security Number:	Home Phone Number:
Annual Compensation:	Date of Hire:
Local Church or Institution:	Date of Birth:
Address:	E-mail Address:
Local Treasurer: (please print)	Treasurer Sign:

I elect to have my compensation reduced during the election period to fund the benefits I have selected below under the above referenced Plan. I realize the election for Medical Expense and Dependent Care Assistance may not be revoked or changed unless it is on account of and **consistent** with a change in status of one of my dependents, my spouse, or myself such as marriage, divorce, annulment, legal separation, death of spouse; change in number of dependents due to birth, adoption, placement for adoption, death, or a court ordered change in custody or medical obligations; change in employment status that affects eligibility for my spouse, my dependents, or myself; termination or commencement of employment, going from part-time to full-time and vice-versa, strike or lock-out, commencement of or return from an unpaid leave of absence, change in worksite or going from salaried to hourly or vice-versa (must affect eligibility); change in eligibility of my dependent(s) on account of attainment of age, student status or any similar circumstance, or either losing or gaining eligibility, becoming entitled to receive Medicare or Medicaid or changing residence that affects eligibility. (Changes in insurance premium rates or plan coverage do not entitle you to change your medical expense reimbursement or dependent care election).

**Please note: If my employment terminates for any reason, I realize that expenses incurred after my date of termination will not be eligible for reimbursement. Date of termination is the 1<sup>st</sup> of the month following termination of employment or retirement. Participants will have 90 days after date of termination to submit claims.**

<b>I request the following amount(s) to be deducted pre-tax: Active Clergy or Lay:</b>	<u><b>Monthly Insurance Premium</b></u>
<b>CLERGY:</b> Health Insurance Premium deducted from my salary: (Total Compensation of \$29,999 or less) Single: \$245.00, Two Party: \$479.00, Family: \$535.00 (Total Compensation of \$30,000 or more) Single: \$307.00, Two Party: \$598.00, Family: \$704.00	
<b>LAY:</b> Health Insurance Premium deducted from my salary: <b>Lay Employees &amp; Diaconal (Active)</b> Single: \$539.00, Two Party: \$1,070.00, Family: \$1,245.00	\$
	<u><b>Election Per Month</b></u>
Medical Expense Reimbursement Program (NOT to exceed \$5,000)	\$
Dependent Care Assistance Program (NOT to exceed \$5,000)	\$
<b>Voluntary</b> Dental premium: Participant only: \$29.37      Participant + spouse: \$58.71 Participant + child(ren): \$85.39      Participant + Family \$114.76	\$
<b>Voluntary</b> Vision premium: Participant only: \$9.02,      Participant + one dep. \$13.08, Participant + family \$23.45	\$
<b>Total deduction amount:</b>	\$

- ( ) I understand that my account is set up to automatically reimburse my Section 125.  
( ) I **do not** wish to automatically be reimbursed. I will submit the claims manually for reimbursement. \_\_\_\_\_(initial)

I realize that all dependent care and medical expenses must be incurred by me or my dependents and must have been incurred during the election period and grace period. I also realize that I can only be reimbursed for dependent care expenses during the hours of the employment of my spouse, if married, and myself and only up to the amount of funds available in my dependent care account at that time. I also realize that if the total calendar year Dependent Care Assistance Program reimbursement exceeds the lesser of my or, if married, my spouse's earned income, then the excess amount will be taxable to me. At the end of each year, I will file Form 2441 with the Internal Revenue Service reporting the name, address and tax identification number of the person or organization providing dependent care services.

I realize that amounts selected for one benefit cannot be transferred to another benefit. I am also aware that the "Grace Period" ends March 15th after the end of the Plan Year during which time I can continue to incur claims and use amounts remaining in my Health Flexible Spending Account or Dependent Care Spending Account. I realize that I forfeit any amount not paid to me within 30 days after the end of the Grace Period or April 14th.

\_\_\_\_\_  
**Signature of Participant**

\_\_\_\_\_  
**Date**

HEALTHCARE BENEFITS OFFICE VERIFICATION

\_\_\_\_\_  
**Approved By**

\_\_\_\_\_  
**Date**