FLEXIBLE SPENDING ACCOUNT SECTION 125 FSA ENROLLMENT FORM
OKLAHOMA ANNUAL CONFERENCE, THE UNITED METHODIST CHURCH FLEXIBLE BENEFIT PLAN
ELECTION PERIOD: From ________/________/2016 Through 12/31/2016

Please Print

Employee Name **(Last) (First) (Middle)**	Local Church or Agency:
Social Security Number:	Church or Agency Address: : **(Street Address, City, State, & ZIP)**
Date of Birth:	Church Phone Number:
Employee Home Address: **(Street Address, City, State, & ZIP)**	Employee Date of Hire:
Employee Home Phone Number:	Local Treasurer: (please print)
Employee E-mail Address:	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 1st of the month following termination of employment or retirement. Participants will have 90 days after date of termination to submit claims.

I request the following amount(s) to be deducted pre-tax from my salary: (Please **circle** the appropriate level of coverage below and enter the monthly amount deducted)		**Monthly Insurance Premium**
ACTIVE CLERGY: Health Insurance Premium deducted from my salary: (Available only to active full time Clergy and under appointment) **STANDARD PLAN:** Single: **$252.00**, Two Party: **$658.00**, Family: **$792.00** **BASIC PLAN:** Single: **$92.00**, Two Party: **$618.00**, Family: **$792.00**		$
		Election Per Month
Medical Expense Reimbursement Program **(NOT to exceed $2,550 annually) New "Benny Cards" for 2016**		$
Dependent Care Assistance Program **(NOT to exceed $5,000 annually)**		$
Voluntary Dental premium: Participant only: **$37.20** Participant + spouse: **$74.40** Participant + child(ren): **$105.52** Participant + Family **$142.70**		$
Voluntary Vision premium: Participant only: **$9.38**, Participant + one dep. **$13.61**, Participant + family **$24.40**		$
Total deduction amount:		$

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. 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 realize that I forfeit any amount not paid to me after the end of the plan year.

____ ____________________

Signature of Participant **Date**

____ ____________________

Approved By **Date**

Med. Exp. Reimbursement / Dependent Care Plans Administered by:
Keystone Flex Administrators, LLC
P.O. Box 5502
Edmond, OK 73083
(Phone: 405-285-1144 / Toll Free Phone: 866-680-8308)