

Election Form – Annual Benefit Election Period

Section 125 flexible benefits enrollment for Goshen College

Plan year: July 1, 2009 to June 30, 2010

Employee name _____ Social Security number _____
First middle last

Birth date _____ GC ID _____ Part time Full time

Address _____
Street City State ZIP code

On the appropriate enrollment form(s) I have enrolled in certain insurance coverage(s). I authorize pretax salary reductions from my wages for the following coverage that I elect through FlexChoice. I understand that these elections will continue indefinitely until I initiate a change due to a qualifying event.

Premium Expense (check the box that indicates the coverage you are choosing):

Medical:

Check one that applies

- Employee and spouse
- Employee and dependents
- Employee and family
- Part-time: premium _____

Dental:

Check one that applies

- Employee only
- Employee and one dependent
- Employee and family

Affac Plans:

Check all that apply

- Accident Premium _____
- Cancer Premium _____
- Specified health Premium _____

Vision:

Choose plan

- Plan B
- Plan C

Choose coverage

- Employee only
- Employee plus one
- Employee and dependents
- Employee and family

Cancer Plus 30:

- Continue current coverage
(not available for new enrollment)

I authorize pretax salary reductions from my wages for the reimbursement accounts in the amounts indicated below in equal increments at each applicable pay period in the plan year. (Please enter both pay period and year amounts.)

Medical Expense Reimbursement Account: \$ _____ per pay period x 24 = \$ _____ per year

Dependent Care Expense Reimbursement Account: \$ _____ per pay period x 24 = \$ _____ per year

I understand and agree that:

- I cannot change or revoke my elections until the next annual benefit election period unless I experience a qualifying event for a change (i.e., marriage, divorce, birth, death, adoption, or change in employment status). Specific rules apply as outlined in the FlexChoice summary plan description.
- Any funds remaining in my reimbursement accounts at the end of the plan year will be forfeited by IRS regulations to my employer.
- If my employment terminates for any reason, I am bound by the terms of the FlexChoice summary plan description.
- Any receipt I submit to my reimbursement accounts must be for an eligible expense incurred during the applicable plan year.

I certify that any expense I submit to my reimbursement accounts has not been reimbursed and will not be reimbursed under any other plan.

Employee's signature Date

To be completed by employee if declining to participate

I have been given the opportunity to participate in FlexChoice (Section 125). However, I decline to participate at this time.

Employee name (please print)

Employee's signature Date



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Unreimbursed Expenses Survey

This is a worksheet for the other side of this form.

1. Estimate your "non-insured" medical costs **per month**:
 - a. Deductibles (\$1,250 for single/\$2,500 for family) \$ _____
 - b. 30 percent of coinsurance medical expenses (\$1,500 for single/\$3,000 for family) \$ _____
 - c. Number of office visits at \$15 per visit \$ _____
 - d. Vision care (eye exams, contacts, glasses) \$ _____
 - e. Dental \$ _____

2. Insurance premiums are taken out of your paycheck tax-free. This applies only to Goshen College plans.

3. If you are a single parent or your spouse works, how much do you pay for dependent day care for children 12 years or younger (including baby-sitting)? This may not exceed \$416 per month.** \$ _____

*Eligible items to include in this section may include any expenses paid for medical care as defined by the IRS: Goshen College health plan deductible, estimated copay amounts, estimated 30 percent coinsurance cost, acupuncture, artificial limbs and teeth, prescription drugs (including birth control pills), nonprescription drugs and medication necessary to treat a medical condition, braces, crutches, dentist, physical exams not covered by plan, eye exam and glasses, weight loss program (as treatment of a specific disease diagnosed by a physician), hearing tests, devices and batteries, support or corrective devices such as orthopedic shoes, and transportation expenses relative to illness (including fare to doctor's office, tabulated as actual expense of gas and oil, or actual mileage plus parking and tolls).

**This account reimburses you for day care expenses that you incur because you are employed. Day care expenses eligible for reimbursement are: a) charges by a licensed day care center or nursery school, b) charges for a babysitter in your home (Social Security number required), and c) dependent care centers/individuals providing day care for dependent adults who spend at least eight hours per day in your household.

Notes

1. If you are married, both you and your spouse must work (unless your spouse is disabled or a full-time student) in order to access the dependent care account.
2. Reimbursement cannot be made for day care payments you make to a relative you claim as a dependent, to your spouse or to your child who is under age 19.
3. Qualified dependents include: a) your child or other dependent 12 years or younger for whom you claim a federal income tax exemption, or b) your spouse or other qualifying relative (as defined by the IRS) who is mentally or physically handicapped.

To apply for reimbursement

Please attach your receipts and documentation to a completed *Reimbursement Request Form*. Forms and addressed envelopes are available at the accounting office and you will receive a supply from MMA.

Forward these items to MMA either by fax or mail. Reimbursement checks will be issued twice monthly. Those received by the first Friday of the month will be paid by the second Friday of the month; those received by the third Friday of the month are paid by the fourth Friday of the month.

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