Annual Pre-Tax Benefit Election Form

Annual Benefit Election Period Plan Year: July 1, 2019 to June 30, 2020

GOSHEN COLLEGE

Name _____ ID# _____ Part/Full Time _____ FTE _____

Address _____ City _____ State _____ Zip Code _____

**** I authorize pretax salary reductions from my wages for the following coverage. ****

Medical

- ☐ Employee Only
- ☐ Employee/Ch
- ☐ Employee/Sp
- ☐ Full Family
- ☐ Part-Time (Grandfathered) $_____

Relation	Gender	Name	SSN	DOB
Self				
Spouse				
Child				
Child				
Child				
Child				

☐ **I do not want Health coverage for Year 2019.** ***Initials*** _____ ☐ **I do not qualify for coverage.**

Dental

- ☐ Employee Only
- ☐ Employee + 1 Dep
- ☐ Full Family

☐ **Same as above**

Relation	Gender	Name	SSN	DOB
Self				
Spouse				
Child				
Child				
Child				
Child				

☐ **I do not want Dental coverage for Year 2019.** ***Initials***_____

Vision

- ☐ Employee Only
- ☐ Employee/Sp
- ☐ Employee/Dep
- ☐ Full Family

☐ **Same as above**

Relation	Gender	Name	SSN	DOB
Self				
Spouse				
Child				
Child				
Child				
Child				

☐ **I do not want Vision coverage for Year 2019.** ***Initials*** _____

Flexible Spending Accounts: *Annual Enrollment Form Required*

☐ **I do not want to contribute to FSA.**

Medical $_____ **Dependent Care $**_____ ***Initials*** _____

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 specific rules or information go to: https://www.goshen.edu/hr/benefit-plan-documents/.

* If my employment terminates, I am bound by the terms of the benefit plan documents.

Signature _____ **Date**_____

Goshen Giving – Grow Goshen! Support Students! *Giving other than through payroll, complete form*

- ☐ I want to give my future gifts through payroll deduction. $_____
- ☐ I'm choosing not to participate.

GOSHEN COLLEGE
FSA Enrollment Form
July 1, 2019 to June 30, 2020

Employee Name	**Social Security Number**	
Address	**City/State/Zip**	
Email Address	**Date of Birth**	**Date of Hire**
Effective Date of Election	**First Pay Date**	
Medical Flexible Spending Account (Maximum Annual Contribution $2,700)	**Per Pay Contribution**	**Plan Year Contribution**
Dep. Day Care Flexible Spending Acct. (Maximum Annual Contribution $5,000)	**Per Pay Contribution**	**Plan Year Contribution**

My employer and I hereby agree that my cash compensation will be redirected by the amounts set forth above for each pay period during the Plan Year (or during such portion of the year that remains after the date of this agreement). I understand that if I do not return this form to my employer by my effective date, I am effectively waiving participation in the flexible spending programs offered by my Employer's Section 125 Cafeteria Plan. I understand that:

- *I cannot change or revoke my election for the Medical Flexible Spending Account and/or the Dependent Day Care Flexible Spending Account unless I have a change in status (including marriage, divorce, death of a spouse or dependent child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other qualifying events.*
- *Any balance, up to $500, remaining in my Healthcare Flexible Spending Account after the end of the Plan Year's Run-out Period can be carried over to the next Plan Year.*
- *Any balance left in my Dependent Day Care Flexible Spending Account after the end of the Plan Year's Run-out Period will be forfeited in accordance with the "Use it or Lose it" provision.*
- *The Plan Administrator may reduce or cancel my taxable compensation redirection or otherwise modify this agreement in the event it is believed that it is advisable in order to satisfy certain provisions of the Internal Revenue Code.*
- *This agreement is subject to the terms of my Employer's Section 125 Cafeteria Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior election and agreement relating to such plan(s). By signing this form I agree to the terms and procedures listed herein.*

Employee Signature X_____ **Date X**_____