Glynn Griffing & Associates
Professional Service. Personal Care.

P.O. Box 16509
Jackson, MS 39236

Cafeteria Plan Election Menu

MANDATORY FIELDS. PLEASE PRINT

HR Approval: _____

Employer/Company: _____

Employee Name: _____ SSN: _____

Address: _____
Street City State Zip Code

Email: _____ DIVISION: _____

Coverage Effective Date: _____ Payroll Effective Date: _____

Pay Cycle: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly (26) ☐ Bi-Weekly (24) ☐ Weekly ☐ 9 Month

Spending Account Plans

Annual Amount		Per Pay Amount
$ _____	Medical Expenses	$ _____
$ _____	Dependent Care Expenses	$ _____
$ _____	_____	$ _____
$ _____	**Total**	$ _____

Payroll Deducted Premiums

Premiums:	Per Pay
Major Medical	$ _____
Dental	$ _____
Cancer	$ _____
Accident	$ _____
Group Term	$ _____
Vision	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
Total	$ _____

Medical Care Reimbursement

I understand that:

a) Expenses cannot be claimed if paid by any insurance.
b) I must submit a Reimbursement Request Form itemizing the expense to be reimbursed, and include supporting evidence as set forth in the Plan.
c) Expenses must be incurred within the Plan Year, regardless of when I actually pay the expense.

Dependent Care Reimbursement

I understand that:

a) Child must be under 13 years of age.
b) Cannot be claimed on Federal Income Taxes if claimed under Flex Plan
c) Must be necessary in order to work
d) The tax savings derived by including dependent care expenses in this Plan should be compared to the tax credit allowed on my income tax return
e) File Form 2441

Participant Agreement

I understand that selection of new insurance coverage does not automatically provide coverage and I must complete an application for insurance. I understand that any election made under the Cafeteria Plan herein is irrevocable and may only be changed at enrollment prior to the start of the new Plan Year, or in the event of a qualified event (i.e., change in marital or dependent status, death of employee's spouse, or dependent, or a spouse's change in employment status).
I cannot change or revoke this agreement prior to the first day of the next plan year, except as permitted by the Plan and/or the Internal Revenue Code.
The Plan Administrator may modify or cancel the amount of my salary reduction under this Agreement if necessary to satisfy certain provisions of the Internal Revenue Code.
The reduction in my cash compensation under this Agreement will be in addition to pay reductions under other agreements or benefit plans.
Benefits under the Plan may be reduced or cancelled by the Employer at any time.
I also understand that if changes in insurance coverages are not made during open enrollment, I will be treated as having continued the same elections in effect for subsequent plan years. During open enrollment, elections must be made in the Spending Accounts or they will be terminated. I am aware that any expenses paid through the Cafeteria Plan are no longer eligible as deductions for federal or state income tax purposes and participation may reduce my future Social Security entitlement.

I hereby agree my cash compensation will be reduced by $_____ per pay period during the Plan Year. Prior to _____ each year, I will be offered the opportunity to change my election.

Employee Signature: _____ Date: _____

Waiver of Participation

I understand that all benefit coverages now offered by the above mentioned employer through payroll deduction are available to me under the above mentioned employer's Cafeteria Plan and that the intent of Plan participation is to reduce the cost of these benefit coverages to me. I have been offered the opportunity to participate in this Plan and do hereby decline this opportunity and elect to receive current compensation. I understand if changes are not made at enrollment, I will be treated as having continued to waive my participation for subsequent plan years.

Employee Signature: _____ Date: _____