first CONCORD
Benefits Group

I.R.C. Section 125 Enrollment Form

www.firstconcord.com
Phone: 402-423-4454
Fax: 402-423-4549
www.myflexonline.com

NACO GROUP: BURT COUNTY .

Plan Year: July 1, 2019 to June 30, 2020 No.Payrolls: 12

FirstName_____ LastName_____ Date of Birth _____ SocSecNo._____

Home Address _____ City_____ State_____ Zip_____

DEBIT CARD REQUEST/ CONTINUATION

I understand that the take care debit card is available to pay only qualified expenses. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by law). www.myflexonline.com

☐ **YES** I want the convenience of using the take care debit card to pay for qualified expenses.

E-MAIL (required-if YES): _____

☐ **NO** At this time, I do NOT want to use the take care debit card.

Flexible Spending Account (FSA)

Allows you to use pre-tax dollars to pay for expenses which are not covered, or are not eligible for payment through any group health care plan(s), under which you or your spouse are covered.

_____ **YES, I elect to participate:** $_____ **Per Pay** $_____ **Annual Amount**

$2,700 maximum election

Dependent Care Spending Account

The Dependent Care Spending Account allows you to use pre-tax dollars to pay for eligible Dependent Care Expenses which allow you or your spouse (if applicable) to work, look for work, or attend school on a full-time basis.

_____ **YES, I elect to participate:** $_____ **Per Pay** $_____ **Annual Amount**

$5,000 maximum election

Personally Owned Insurance Account

This account allows you to pay for personally owned insurance premiums (non-medical) on a pre-tax basis.

_____ **YES, I elect to participate:** $_____ **Per Pay** $_____ **Annual Amount**

Group Premium Payment Plan

The Premium Payment Plan allows you to pay for your portion and your dependent(s) portion of employer-provided benefits on a pre-tax basis. I understand that my share of these insurance benefits will be paid with pre-tax dollars.

_____ **YES, I elect to participate**

NOTE: if your group insurance premiums change during the plan year, your employer will automatically adjust this without the need for a new enrollment form.

CASH OUT OPTION

_____ **YES, I elect Cash:** In lieu of the group health plan you can opt to take cash. NOTE: This option will be taxed at your regular income tax rate. **(AFTER-TAX)**

_____ **NO, I WAIVE my right to participate and understand that I will lose all tax savings I may have received as a participant.**

My employer and I agree that my taxable income will be reduced each pay period by the amount set forth in this agreement. I understand that I may only change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year will be forfeited and will *not* be paid to me in cash or used in a later plan year.

Employee Signature: _____ **Date:** _____