BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.
P.O. Box 98025, Baton Rouge, La. 70898

# Section 125
# Premium Only/Flexible Spending Account
# Employee Election Form
**www.ezflexplan.com/bcbsla**

Employer Name: _____ Date of Hire: _____

Employee Name: _____ Employee Social Security Number: _____

Mailing Address: _____ _____
*(Please print clearly)* Street or P.O. Box City/State/Zip

Date of Birth: _____ Email Address (Optional): _____

Plan Year _____ through _____ Effective Date _____

The Employer and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

## Election and Compensation Reduction Agreement for Coverage Under Certain Benefit Plans

On the appropriate benefit enrollment form(s), I have enrolled for certain dental, disability, life insurance, and/or health insurance coverages. I elect to receive the following coverage under the Cafeteria Plan:

**BENEFIT ELECTION** - I elect to allocate the following amount on a **Per Pay Period** basis to the purchase of the benefits chosen below. I understand that my compensation shall be reduced by dollar amounts for the levels indicated to create flexible benefit plan dollars during the plan year.

### Section A: Premium Only

❑ I elect to have my insurance premium(s) payroll deducted on a pretax basis

*SECTION B TO BE COMPLETED ONLY IF A FLEXIBLE SPENDING ACCOUNT PLAN IS IN PLACE*

### Section B: Flexible Spending Account Plan

❑ I elect to have the following payroll contributions deducted from my paycheck.

❑ Medical Reimbursement Plan Eligible items include but not limited to deductible, copay, Rx, vision, dental, ortho, over the counter

$_____ per period X _____ = $_____ Annually

❑ Dependent Care Plan Childcare or care of disabled spouse or dependent

$_____ per period X _____ = $_____ Annually

Note: There may be limits on the amounts which can be used for certain benefits. You should review your Summary Plan Description and ask your Administrator if you have any questions.

With regard to my salary redirection agreement and my election of benefits, I understand that:

- I may not change elections during the Plan Year unless there is a change in my family status (e.g., marriage, divorce, death of my spouse or child, adoption or birth of my child, or termination of employment of my spouse).
- The Administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
- My election of salary redirections and benefits will remain in effect only for the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for that Plan Year.
- Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year.
- My Social Security benefits may be slightly reduced as a result of my election.

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

NAME AND RELATIONSHIP _____

ADDRESS _____

I hereby authorize the Employer to withhold a service fee of $ _____ per pay, if applicable from my compensation for administrative costs of the Plan.

***~ Over ~***

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

**X** _____

Employee's Signature

**WAVIER**

For the period _____, through _____, I have been offered the opportunity to participate in the Blue Cross and Blue Shield of Louisiana Cafeteria Plan and I decline. I understand that if I should later desire to participate I will have to wait until the next Plan Year unless I experience an official change in family status.

_____ _____

Employee's Signature Date