Montrose County – 2021 Plan Year
Sec. 125 Cafeteria Plan FSA
Benefit Election Form and Salary Reduction Agreement

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Employee Name (Last, First, MI) Social Security No.

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Employee Mailing Address Phone #

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Annual Salary Hire Date

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown under the Reimbursement Accounts headings shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date the Plan. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction or after-tax deduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit **Salary Reduction per Pay Period**

Reimbursement Accounts

FSA Medical Expenses.. $____________

FSA Dependent Care .... $____________

Pretax Deduction for Reimbursement Accounts ....$____________

Total Deductions………………………………………………………………………...$____________

I have read the Summary Plan Description and the attached Plan Information Summary Montrose County has given me.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as listed on the Status Change Matrix I received with the Summary Plan Description.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate.**

Signature____ Date____________________

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate.**

Signature____ Date____________________