I.R.C. Section 125 Enrollment Form

first CONCORD Benefits Group

www.firstconcord.com
Phone: 402-423-4454
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NACO GROUP: _____.

Plan Year: Jul 1, 2024 to Jun 30, 2025 No.Payrolls: _

Mid-Plan Year Enrollment – Eff: _____.

FirstName_____LastName_____ Date of Birth _____ SocSecNo._____

Home Address _____City_____State_____Zip_____

Email Address _____

DEBIT CARD REQUEST/ CONTINUATION

I understand that the 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).

☐ **YES** I want the convenience of using the 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**

$3,200 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

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**

_____ **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:** _____

Flexible Spending Account (FSA)

- **Only individuals eligible for employer-provided major medical coverage can be offered the health FSA (Unreimbursed Medical).**
  This account allows you to pay for out-of-pocket medical, dental, hearing and vision expenses with pre-tax dollars. Examples of these expenses may be, but are not limited to insurance deductibles, medical exams, hearing, dental expenses, vision expenses, orthodontia and Prescription Drugs. All health care expenses must be for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body to be a qualified health care expense under the plan.

Dependent Day Care Spending Account

This account allows you to pay for day care expenses on a pre-tax basis throughout the plan year.
Only those dependent care expenses which allow you (and your spouse if you are married)to be gainfully employed are eligible. This excludes care which is primarily for medical or educational purposes.

Eligible Dependents - Dependent children under age 13, or any other dependent who is incapable of caring for himself or herself, whose principal residence is your home and you can claim as a dependent on your federal tax return.

Eligible Expense - Reimbursement is limited to the income of the lower earning spouse and also $5,000/year; $2,500 if married, filing a separate return. Married employees in separate plans can only be reimbursed in total $5,000. The reimbursement amount may not exceed the employee's salary; or for married employees, the lesser of the spouse's salaries (subject to certain exceptions). If your spouse is a full time student or incapable of caring for himself or herself, the maximum is $200 per month for one child or $400 per month for two or more children.

Eligible Providers -

- A licensed day care center which cares for six or more persons
- A unlicensed provider caring for less than six persons
- An in-home provider, as long as that provider is not your child under age 19 or someone you or your spouse can claim as a dependent for tax purposes.

For more information, see IRS publication 503, available from your local IRS office.

Group Insurance Premiums

This account allows you to pre-tax your group-sponsored insurance plans. Group term life up to a maximum of $50,000 may be deducted pretax. Please note that most health insurance provides life insurance as well. This needs to be noted in your calculations. (i.e. medical life insurance $10,000 therefore $40,000 term life may be deducted). Dependent life insurance is not eligible for pretax deductions.

All claims will be paid from actual bills, or copies of actual bills. For Unreimbursed Healthcare Spending Account claims you may also submit a copy of your EOB form from your insurance carrier. These must contain the name of the provider of service, date(s) that the services were provided, and the amount charged. They must be attached to a completed First Concord Benefits Group "Claim for Reimbursement" form.