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A division of Educators Financial Services, Inc.

## Section 125 Flexible Benefits Plan – Benefit Election Form

For Plan Year Ending: \_\_\_\_\_ Employer: \_\_\_\_\_

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

I elect to receive the following benefits (in addition to payroll-deducted insurances) in accordance with, and subject to the provision of the plan in the amounts stated below:

Dependent Care\* .....\$ \_\_\_\_\_

Group-Term Life Insurance\* (on employee's life only).....\$ \_\_\_\_\_

Outside Health Insurances.....\$ \_\_\_\_\_

Health.....\$ \_\_\_\_\_

(out-of-pocket medical, dental, vision, drug, co-pay deductibles, and other health expenses)

(If you elect in this category, you cannot have an HSA!)

Total Election (may not exceed \$20,000).....\$ \_\_\_\_\_

\*Please refer to limitations stated in the Flexible Spending Plan Employee Worksheet or Summary Plan Description.

1. Pay Reductions. I elect to reduce my pay at such times as set out in the Plan by the amount noted above.
2. Understandings. I understand my election in each category (including payroll deducted insurance) may not be dropped or changed for the plan year unless I submit an Election Change Form and meet the requirements for changing my election. I understand I may not "shift" amounts from one category to another, and that if I do not incur expenses of at least the amount of my election during the plan year in each of the categories, I will forfeit the unused amount. I understand my election may be reduced under the terms of the plan if I am a "highly compensated employee" under certain circumstances.
3. Elections. I understand I am authorizing the deductions of the above expenses from my pre-tax salary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**This form must be submitted to the employer prior to the first day of the plan year**