VANTAGE FINANCIAL GROUP, INC.
A SINGLE-SOURCE FINANCIAL SERVICES COMPANY

Stark County Schools

Flexible Benefit Plan
Election Form and Compensation Reduction Agreement

ACCOUNT HOLDER INFORMATION:			
Name:	SSN:	Date of Birth:	
Street Address:	City:	State:	Zip Code:
E-Mail Address:	District:		
First Payroll Deduction Date:	Benefit Effective Date: **January 1, 2015**		
Payroll Schedule (i.e. Weekly, Bi-Weekly, Bi-Monthly, etc.):			

With regard to my salary redirection agreement and my election of benefits, I understand that:
In accordance with my rights under the plan, I elect the following benefits and designate the following amount for the plan year specified above. The Employer and I agree that my cash compensation will be reduced by the amount set forth below for each pay period and plan year (or during such portion of the year as remains after the date of this agreement).

ANNUAL ELECTION:

Flexible Spending Accounts:

	Amount Per Pay	Annual Amount
Group Sponsored Insurance Premiums	$	
Medical Care Reimbursement Account *maximum contribution $2,500*	$	$
Dependent Care Reimbursement Account *maximum contribution $5,000*	$	$

IMPORTANT INFORMATION ABOUT THE DEBIT CARD:

Your flex debit card may be used for immediate payment of eligible medical or dependent care expenses at qualified providers of service that accept FSA debit cards. Remember that debit card transaction receipts must still be saved. A review of electronic transactions may result in a request to provide itemized bills or transaction receipts to substantiate each claim. Failure to provide the necessary documentation may result in the deactivation of your debit card.

AUTHORIZATION TO RELEASE ACCOUNT INFORMATION:

☐ **No** ☐ **Yes (Complete the section below)**

By signing and dating this document, I am authorizing Plan Services to discuss and/or release information regarding my flexible spending account to:

Name:	Relationship:	SSN:

- This authorization allows Plan Services to discuss or release the requested information directly to the person stated above, and to no other parties.
- This authorization applies to any flexible spending, dependent care, mass transit, parking, or deductible reimbursement plans I may have with your company.
- This authorization is valid until notified otherwise, and can be revoked by the member of the plan at anytime.

Employee's signature: X _____ **Date:**

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

1. I may not change elections during the Plan Year unless there is a qualified change in my family status. A change in group health (medical, dental or vision) plan coverage does not qualify as a change in family status. Terminated employees who are rehired during the same plan year may not participate in the in the flexible benefit plan until the beginning of the next plan year.
2. The administrator is authorized to adjust the amount of my salary redirection and benefit 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.
3. My right to any benefits hereunder is subject to all terms and conditions of the Plan and the terms and conditions of any other Plan through which a particular benefit is provided.
4. 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 year.
5. By electing coverage under an Employer sponsored group health plan, I will automatically have my premium contribution payroll deducted on a pretax basis under the Plan.

Employee's Signature: X _____ **Date:** _____