FLEXIBLE BENEFIT PLAN
2023 – 2024 Plan Participation Form
Group Plan # 1275

Company Name: Pennybyrn (Maryfield, Inc)

Employee Name: _____ ID # _____

Email address: _____

Mailing address: _____

_____

Employee Hire Date: _____ **Birth Date**: _____

❑ REQUEST TO PARTICIPATE IN FLEXIBLE SPENDING ACCOUNT

Medical / Dental / Vision Care - Benefit Election $ _____ total per year

Maximum benefit election for **2023-2024 is $3,050 per year**. FSA covers costs paid by you and your dependents that are not reimbursed by insurance (ex: deductibles, coinsurance, eye care, orthodontics).

***ACKNOWLEDGEMENT**: I understand that the above FSA amount:*

- is selected for an entire Plan Year (*10/1/23 – 9/30/24*);
- will be deducted from each paycheck on an equal basis for 26 pay periods, beginning *10/19/23;*
- may be changed only if certain events occur in my family and/or employment status. *(This change must be made within 31 days of the event.)*
- will end on 9/30/24 and employees wanting to participate in following plan years must complete a new request to participate each plan year.

I further understand that the total amount elected must be used during the current Plan year or it will be forfeited on 9/30/24 under the terms of the Internal Revenue Code. *I may choose to utilize the Plan's amendment to allow for an extended 2.5-month grace period and use the elected amount through December 15, 2023.* In the event of termination of employment, expenses must be submitted within the time limit set by the Plan or reimbursement will be forfeited.

❑ REQUEST TO WAIVE

The Flexible Benefit Plan has been explained and I elect to waive participation. I understand that my next opportunity to enter the Plan will be at the start of the next plan year (10/1/24); however, if not changed, this waiver will continue in effect indefinitely.

_____ _____

Employee Signature ***Date***