CHURCH OF THE BRETHREN
INSURANCE SERVICES
A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.
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Election Form Instructions

Brethren FlexCare

(Employer Groups)

When completing this form, it is essential that you know what **your share** of the cost of each premium will be. Contact your employer to confirm the amount of the contribution that will be made on your behalf.

PART I — IDENTIFYING INFORMATION

Print or type your name, home address, home telephone number, birth date, Social Security number, email address, and the name of your employer.

Your employer may offer some or all of the coverages listed below.

PART II — PREMIUMS

A. Medical Plan
If your employer offers this benefit and you choose to elect the coverage, enter the **employee's** annualized premium for your medical plan on line A. Your employer will provide this information to you.

B. Dental Plan
If your employer offers this benefit and you choose to elect the coverage, check the boxes for the option and coverage level you desire. On line B enter the annualized premium for the coverage you have elected. **It is assumed that the entire premium amount will be paid by the employee.** If your employer will contribute a portion of the premium, enter only the annualized amount you will owe after your employer's contribution. Your employer will provide your rate information to you.

C. Vision Plan
If your employer offers this benefit and you choose to elect the coverage, check the boxes for the option and coverage level you desire. On line C enter the annualized premium for the coverage you have elected. **It is assumed that the entire premium amount will be paid by the employee.** If your employer will contribute a portion of the premium, enter only the annualized amount you will owe after your employer's contribution. Your employer will provide your rate information to you.

D. Accident
If you wish to elect the Accident Plan, check the boxes for the option and coverage level you desire and fill out the Accident Plan Enrollment form. Refer to the rate sheet and enter the annualized amount of the coverage you have elected on line D. **It is assumed that the entire premium amount will be paid by the employee.** If your employer will contribute a portion of the premium, enter only the annualized premium you will owe after your employer's contribution.

PART III — HEALTH SAVINGS, MEDICAL REIMBURSEMENT, AND DEPENDENT CARE ACCOUNTS

Note: Through Brethren FlexCare, you are able to have your employer withhold your share of premiums on a pre-tax basis. However, this must be done separately from your health savings account. The IRS does not allow premiums to be reimbursed from an HSA; only expenses that are not reimbursed by your insurance plan may be considered as eligible expenses for reimbursement from your HSA.

E. Health Savings Account
You may elect the HSA benefit if you are enrolled in a high-deductible health plan provided by your employer. You may not elect this benefit if you are also enrolled in a traditional-deductible health plan as secondary coverage.

If you wish to establish an HSA, enter the amount you wish to elect for pre-tax salary reduction for this plan year on line E. If you do not wish to establish an HSA, enter "0" on line E.

Note: You may make tax-free contributions to your HSA outside the salary reduction agreement as long as your total contributions do not exceed the annual maximum allowed by the IRS.
The annual maximum HSA contribution is the amount for individual (self-only) coverage and family (more than one person) coverage set by the IRS for this tax year. Contact your employer for these amounts. Your annual maximum contribution is based on the total contributions made by you and your employer. If you are age 55 or older, you may contribute an additional $1,000.

If your spouse is age 55 or older, he or she may contribute an additional $1,000 to his/her own HSA. Your spouse must be enrolled in a qualified high-deductible health plan and be otherwise eligible.

F. Medical Reimbursement Account
You may elect the MRA benefit if you are enrolled in the traditional-deductible health plan provided by your employer or if you are enrolled in the high-deductible health plan provided by your employer but are not eligible to make HSA contributions. MRAs are also available on a fee basis for employees who are not enrolled in the Brethren Medical Plan.

If you wish to establish an MRA, enter the annual amount you want to elect to this account on line F. **This amount must be divisible by 12.** A minimum of $102 is required. A maximum of $2,499.96 can be allocated. If you do not wish to establish an MRA, enter "0" on line F.

G. Dependent Care Account
If you elect traditional-deductible or high-deductible health plan coverage provided by your employer and you wish to establish a DCA, enter the annual amount you want to elect to this account on line G. **This amount must be divisible by 12.** A minimum of $102 is required. A maximum of $4,999.92 can be allocated, or $2,499.96 for a married participant who files a separate tax return. If you do not wish to establish a DCA, enter "0" on line G. DCAs are also available on a fee basis for employees who are not enrolled in the Brethren Medical Plan.

PART IV — AFTER TAX PREMIUMS

Note: If you are interested in enrolling in the Life, Long-Term Disability, or Short-Term Disability plans but did not enroll within 31 days of your first day of employment, then you must go through the late enrollment process. Contact Brethren Insurance Services for further information.

H. Long-Term Disability
If your employer offers this benefit and you choose to elect the coverage, enter the **employee's** annualized premium for this plan on line H. Your employer will provide this information to you.

I. Basic Life and Accidental Death and Dismemberment
If your employer offers this benefit and you choose to elect the coverage, enter the **employee's** annualized premium for this plan on line I. Your employer will provide this information to you.

Note: The employee's portion of the Life insurance premium may be withheld on a pre-tax basis for a benefit of up to $50,000.

J. Supplemental Life
If your employer offers this benefit and you choose to elect the coverage, enter the **employee's** annualized premium for this plan on line J. Your employer will provide this information to you.

K. Short-Term Disability
From the STD budget worksheet, enter the employee's annualized premium for the plan on line K. **It is assumed that the entire premium amount will be paid by the employee.** If your employer will contribute a portion of the premium, enter only the annualized amount you will owe after your employer's contribution.

PART V — TOTAL

Add lines A-K and enter the sum on line L. This is the total amount you have elected to spend in the upcoming plan year.

PART VI — SIGNATURES

Your signature certifies that these are the choices you have made under the FlexCare Benefit Program, that you understand they are irrevocable for the plan year unless you have a qualified change in status, and that any money remaining in your Medical Reimbursement Account or Dependent Care Account after March 15 following the end of the plan year will be forfeited. Your signature also authorizes your employer to implement the salary reduction shown on line M.

Your employer must sign the election form attesting to any premium subsidies indicated. Your employer's signature also acknowledges the salary reduction indicated on line M.