AMERICAN FIDELITY
a different opinion

SCCCD Section 125 Pre-tax Election Form
Employee Benefit Election/Salary Reduction Agreement

Employer: State Center Community College District **Plan Year:** / / through / /

Employee Name: **SSN:**

Employee Address:

Email: **Phone #:** ( )

S125 BENEFIT SUMMARY

Mark box to elect		Effective Date Benefits will complete	Benefit/Company	Section 125	After-Tax Payroll Deduct	Employer Paid
			Major Medical/ Pre-tax medical plan employee payroll deduction			
			To Enroll in the voluntary products below call American Fidelity at (559) 230-2107 ext 0			
			Health Flexible Spending Account/AFA	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Dependent Day Care Flexible Spending Account/AFA	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Monthly Flex Admin Fee/AFA	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Monthly Flex Card Fee/AFA	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Cancer Insurance/	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Life Insurance/	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Disability Insurance/	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Accident Insurance/	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Health Savings Account(HSA)/	Contact American Fidelity at (559) 230-2107 ext 0 to enroll		
			Other:			
			Totals:			

FLEXIBLE SPENDING ACCOUNT ENROLLMENT

ACCOUNT TYPE	ANNUAL ELECTION	HEALTH FSA CARD (Check one below)
Health Flexible Spending	$	☐ New Participant / Replacement Card
Dependent Day Care Flexible Spending	$	☐ Existing Participant with Card
Limited Purpose Health Flexible Spending	$	☐ I do not want a Health FSA Card

ELIGIBLE DEPENDENTS (Must be at least 18 years of age)

(Health FSA Card will be mailed to new dependents or dependents with a replacement card number listed. For existing dependents listed the Health FSA Card will be reloaded with your new election.)

Dependent Name 1: _____ Relationship: _____ ☐ New / Replacement Card Request ☐ Existing

Dependent Name 2: _____ Relationship: _____ ☐ New / Replacement Card Request ☐ Existing

Dependent Name 3: _____ Relationship: _____ ☐ New / Replacement Card Request ☐ Existing

TERMS AND CONDITIONS

I hereby authorize the above payroll reductions as my contribution to my Employer's Section 125 Plan.

I understand that:

- Execution of this benefit election/salary reduction agreement does not automatically institute insurance coverage; in most instances an application for insurance must be completed. Premiums charged for insurance coverage may be adjusted by the carrier issuing the contract and my "take-home" pay may be higher or lower depending on the selections made.
- If I have elected the HSA benefit, I certify that I have met all the HSA eligibility requirements, which have been separately disclosed to me, and that I will notify the Employer immediately in writing if I cease to meet any of the conditions for HSA eligibility during any month of the plan year.
- I have received a copy of the **Rules of Participation** and understand and agree to the terms and conditions of participation in the Section 125 Plan, Health Flexible Spending Account(s) and/or Health FSA Card.
- If I do not repay the Health FSA for an overpayment due to an ineligible expense or other reason, my employer may make a deduction from my wages to repay the overpayment.
- If I have elected a Health FSA Card, I certify (1) the Health FSA Card will only be used to pay for the eligible medical expenses of myself, my spouse, and my dependents; (2) the Health FSA Card will not be used for expenses that have already been reimbursed; (3) I will not seek reimbursement under any other health plan for expense paid for with the Health FSA Card; and (4) I will acquire and keep sufficient documentation for expenses paid with the Health FSA Card.

This authorization replaces any previous authorization I have made. ☐ Waive Participation

Employee Signature: _____ **Date:** _____