Lockard & Williams
L & W
INSURANCE SERVICES, P.A.

FLEXIBLE BENEFITS PLAN

ELECTION FORM

To enroll, complete the following information, sign the form and return it to your Risk Management Representative. PLEASE PRINT OR TYPE

PLAN INFORMATION

EMPLOYER NAME: Okaloosa County Board of County Commissioners PLAN YEAR: October 01,2017__ to September 30, 2018__

EMPLOYEE INFORMATION

NAME ______ Last First MI

DATE OF HIRE (Required) ______ MM / DD / YY

SOCIAL SECURITY NUMBER ______

MAILING ADDRESS ______ Number & Street City State Zip Code

DATE OF BIRTH ______ MM / DD / YY

E-MAIL ADDRESS ______

PHONE NUMBER ______ Include Area Code

GENDER ☐ M ☐ F

LOCATION / DEPARTMENT ______

PARTICIPANT'S EFFECTIVE PLAN DATE ______ MM / DD / YY (Only if different than beginning of Plan Year shown above)

DATE OF FIRST PAYROLL DEDUCTION ______ MM / DD / YY

ELECTION INFORMATION

I understand that the rules of the Internal Revenue Code allow me to use part of my salary on a pre-tax basis to purchase one or more of the following qualified benefits.
I hereby elect to participate in my employer's Flexible Benefits Plan as indicated below.

OPTION I

PREMIUM CONVERSION ACCOUNT (PCA OR POP)
The group insurance premiums you pay through payroll deductions.

PT		PT	AT
EMPLOYEE MEDICAL	**Vision**	__________	__________
YES ____	**DENTAL**	__________	__________
NO ____	**LIFE**	__________	__________

PLEASE CHECK YOUR ELECTION(S) AND FILL IN AMOUNT IF APPLICABLE

BENEFIT ELECTION OPTIONS	ELECTION	DEDUCTION		
OPTION II **HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)** You can elect up to the maximum amount as designated by your employer's Plan.	YES ☐ NO ☐	$______ PER PAY PERIOD	No. OF PAYCHECKS (i.e. 12, 26, etc.)	$______ ANNUAL
OPTION III **DEPENDENT CARE ASSISTANCE PLAN (DCA)** Maximum of $5,000 per Plan Year if single parent or if married and filling a joint Tax Return. Maximum of $2,500 if married and filing separately.	YES ☐ NO ☐	$______ PER PAY PERIOD	No. OF PAYCHECKS (i.e. 12, 26, etc.)	$______ ANNUAL

PARTICIPANT ELECTION AUTHORIZATION

I have reviewed and understand the terms and conditions on the back of this page and in my company's Summary Plan Description. I understand that I can not change or revoke this election at any time during the Plan Year unless I have a Qualifying Life Event change (including marriage, divorce, death, birth or adoption of a child, change or termination of spouse's employment, change in dependent care provider or such other events as the Plan Sponsor determines will permit a change or revocation of an election). I further acknowledge that **I am responsible for keeping all receipts verifying all eligible expenses claimed under the Win flex Card and must submit such receipts to Lockard & Williams Insurance Services, Inc. (LWIS) for claims substantiation upon request.**

CHOOSE ONE:

☐ YES, the benefits of this Plan have been explained to me and I elect to participate as indicated above. **I have read the disclosure on the back of this form and hereby agree to the terms of the disclosure by signing this form.**

☐ NO, I do not want to participate in a FSA or DCA at this time, but I understand that I will be treated as having elected to continue my benefit coverage and amount of compensation redirection then in effect for the new plan year for insured benefits only. I further understand that I will not have another opportunity to enroll in an FSA or DCA until the next Open Enrollment period unless I have Qualifying Life Event change.

OPTIONAL:

☐ I would like to request an additional card for my spouse or tax dependent:

ADDITIONAL CARDHOLDER NAME ______ DATE OF BIRTH (MM /DD/YY) ______ SOCIAL SECURITY NUMBER ______

PARTICIPANT'S SIGNATURE: ______ DATE: ______

HUMAN RESOURCES' SIGNATURE: ______ DATE: ______

TERMS AND CONDITIONS

Qualifying Medical Care and Dependent Care Expenses: I understand that reimbursement will be available only for "qualifying medical care expenses" as listed under §213 and "qualifying dependent care expenses" as listed under §129 and §21 of the Internal Revenue Code for me and my eligible dependents. These expenses must be incurred while I am enrolled in the Plan. I agree to notify the Plan Sponsor or LWIS if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to repay the Plan on demand by way of check or payroll deduction for any expense paid for with the Win Flex card that is not allowed under §213, §129 or §21 of the Internal Revenue Code. I attest that I understand claimed medical expenses can not be reimbursed under the Healthcare FSA Plan if the expense has been or will be paid in the future by any other plan and **acknowledge that the medical expenses have not been reimbursed or are not reimbursable under any other insurance plan coverage.** I further acknowledge that I am responsible for keeping all receipts verifying all eligible expenses claimed under the Plan and must submit such receipts to LWIS for claims substantiation, upon request.

Participation Rules: I understand that reimbursement account eligibility, enrollment and benefits information is available from my Plan Sponsor. I authorize payroll deductions for the benefit elections indicated on this Election Form. I understand that I cannot change or revoke this compensation reduction agreement at any time during the Plan Year except for the occurrence of a Qualifying Life Event. In the case of a Qualifying Life Event, I must complete a Change Form no later than 30 days after the date the Qualifying Life Event occurs if I want to enroll in a reimbursement account or change my reimbursement account elections or amounts. Any amounts remaining in the account(s) represented by this Election Form at the end of the Plan Year, past the claims filing limit, will be forfeited to the Plan under the guidelines of the Internal Revenue Code.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE PLAN SPONSOR'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

AUTHORIZTION

I authorize the use and disclosure of my protected health information as described below:

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a healthcare provider, a health plan, my employer, or a healthcare clearinghouse and that relates to: (i) my past, present, or future physical or mental health or conditions; (ii) the past, present, or future payment for the provision of healthcare to me.

Lockard and Williams Insurance Services, Inc. (LWIS) is authorized to use or disclose my protected health information for the purpose of administering my §125 account. **I further authorize LWIS to release my protected health information to my spouse and/or my tax dependent(s). I understand that I may decline disclosure of my protected health information (to my spouse and/or tax dependent(s)) by submitting a writing notification to LWIS.**

All protected health information pertaining to the reimbursement of a §125 claim may be used and disclosed by LWIS.

I understand that if my protected health information is to be received by individuals or organizations that are not healthcare providers, healthcare clearinghouses or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to LWIS, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that LWIS already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage by LWIS and, by law, LWIS has a right to contest the coverage.

I understand that this authorization expires upon termination of my employer's plan.