690 John Adams Parkway Idaho Falls ID 83401
www.ifschools.org
(208) 525-7500

Sec. 125 Cafeteria Plan
Salary Reduction Agreement for 2018-2019 Plan Year

Employee Name (Last, First, MI) *Please Print* ______________________ Home Phone Number ______________

Employee Street Address ______________________ City State Zip Code

Date of Birth ______________________ Social Security Number ______________________

E-mail address ______________________ Mother's Maiden Name (Security Purposes Only) ______________________

Print Name as it will appear on 1st Card (21 characters maximum) ______________________

Print Name as it will appear on 2nd Card (optional) (21 characters max) ______________________

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the plan effective date shown above. I further authorize future adjustments in the amount of my salary reduction if the carrier changes the cost of coverage in any program selected below during the plan year. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed. Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by entering the total per pay period cost and the total amount paid by the pre-tax reduction or after-tax deduction.

Reimbursement Plans

Please list annual election. To calculate your per paycheck amount divide total amount by 12 for the plan year. For new hires, divide by number of remaining checks

General Purpose Health FSA ($2,650 max) $________

Dependent care Assistance Plan (cards will not be issued for a dependent care account)
$2,500 max for single / $5,000 max for married filing joint $________

TOTAL DEDUCTIONS .... $________

ALL FLEX CLAIMS MUST BE INCURRED BY AUGUST 31ST OF EACH PLAN YEAR.

ALL REQUESTS FOR REIMBURSEMENT MUST BE SUBMITTED BY NOVEMBER 30TH OF THE FOLLOWING YEAR

ONCE A NEW PLAN YEAR HAS STARTED, PLEASE DO NOT USE YOUR DEBIT CARD TO PAY FOR SERVICES RENDERED IN THE PREVIOUS PLAN YEAR.

*my*SourceCard™ Enrollment Agreement

As a participant in one or more of the Reimbursement Plans indicated on this form, you will be issued a *my*SourceCard™ MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to the terms of this Agreement and the Cardholder Agreement that will be provided to you with the Card. You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank, or ATM. You understand that the Card is to be used *exclusively* for Qualified Expenses as defined by the Plan(s) in which you participate. If the Card is issued pursuant to a Reimbursement Plan as indicated on this form and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-Qualified Expense. You agree to save all invoices and receipts related to any expense paid with the Card and upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-Qualified Expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, personal check or ACH draft, or a deduction from your paycheck.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in status event as listed on the Status Change Matrix available with the summary plan description.
If I experience a qualifying event I understand I must notify Human Resources within 30 days.
I understand that the cards are available for medical expenses only.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate.**
Signature____ Date__________

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate.**
Signature____ Date__________

Forms can be emailed or faxed to 208-529-4698 or cs@amerins-serv.com. Please contact American Insurance Service at 208-529-3541 or 1-877-878-3541 if you have any questions.

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM
Idaho Falls School District #91

Reimbursement Account
Employee Direct Deposit Authorization Form

STEPS FOR COMPLETING THIS FORM

1. Fill in all boxes below.
2. Attach voided check (not deposit slip).
4. Sign and date form.
5. If the account is not in your name alone, have the other account holder also sign and date form.

Last Name	MI	First Name

Social Security Number	Home Phone	Work Phone

Check Action New/Change/Cancel	Effective Date Month/Day/Year	Acct. Type Checking or Savings	Ownership of Account Self/Joint/Other

------------------------------ATTACH A VOIDED CHECK HERE. ------------------------------

DO NOT attach a Deposit Slip because deposit slips do not show the necessary information.

Joan Doe
Anywhere, USA

PAY TO THE ORDER OF ____________________ $ ____

____________________________________ DOLLARS

YOUR TOWN BANK
YOUR TOWN, AR 123456

FOR ____________ VOID

⑆25550005⑆ 1234556789022⑈

By signing this agreement, I authorize American Insurance Service to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Signature: ______________________________ Date: ______________

If the account is a joint account or in someone else's name, that individual must also sign to indicate agreement with the statement above.

Signature: ______________________________ Date: ______________