ALERUS

*For employer internal use only, Alerus does not accept this form.*

# ALERUS FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION FORM
## TO

You are **required** to complete this election form at the **beginning** of each new plan year. Failure to complete this election disqualifies you from participation in the Flexible Spending Accounts until the beginning of the next plan year unless you have a change in family status.

## EMPLOYEE INFORMATION

| Employer Name | | Employee Name | Division | | |
|---|---|---|---|---|---|
| | | | | | |
| Employee Number | | Election Effective Date | Date of Hire | | |
| | | | | | |
| Social Security Number | Date of Birth | Email | Phone | | |
| | | | H - | W - | C - |
| Address | | City | State | Zip | |
| | | | | | |

## FLEXIBLE SPENDING ACCOUNT ELECTION

Your employer sponsors a Section 125 plan which allows you to pay for your portion of any applicable health and/or other qualified welfare plan premiums with pre-tax dollars.

- If you wish to participate, enter the annual election amount deduction for the benefits checked available to you (please note: not all plans offer all benefits).
- If you do not wish to have such premiums deducted from your pay on a pre-tax basis, enter zero (0) in the annual amount deduction. Also, you must attach a signed letter to this form, indicating your election to have premiums deducted on an after-tax basis.

Available ☐

### Traditional Health FSA

Annual Amount
$

Annual Amount _____ / ____ # of Pay Periods = _____ Per Pay Period

I understand that in the event I terminate employment during the plan year, I cannot submit any voucher for Health FSA claims incurred after the termination date, unless I elect the COBRA extension. I understand that, by electing the COBRA extension, I could continue to submit eligible Health FSA claims that are incurred during the COBRA extension until the end of the plan year.

Available ☐

### Dependent Care FSA

$5,000 annual limit if single head of household, $5,000 for married and filing jointly, or $2,500 for married and filing separate tax returns. Enter zero (0) to decline participation.

Annual Amount
$

Annual Amount _____ / ____ # of Pay Periods = _____ Per Pay Period

I understand that, for any given reporting period, any reimbursement I receive will not exceed the balance in my Dependent Care FSA. If I should terminate employment during the plan year, I understand that I can continue to submit claims for expenses until I have received my remaining Dependent Care FSA balance. However, I will no longer be permitted to make contributions to my Dependent Care FSA after termination.

## SIGNATURE

I hereby authorize the company to make payroll deductions in the amount(s) above for the reimbursement account(s) I have elected. If I have entered zero (0) in any section above, I have chosen not to participate in the plan at this time. I understand that I may not elect to participate later for this plan year unless I experience a change in status as defined by the Plan Document.

_____ _____

Participant Signature Date