DAVEVIC

PARTICIPATION FORM FOR THE FLEXIBLE BENEFITS PLAN

EMPLOYER NAME: _____

Plan Year: 7/1/2024 through 6/30/2025

FSA

Employee Name (required)_____ **Date of Birth** (required)_____

SSN (required) _____ **Email** (required)_____

**IMPORTANT: Email will only be utilized for plan notifications.*

Home Address (required) _____

Street City State Zip code

1st Payroll Effective Date: _____ **Paycheck Frequency:** _____

Option I: Healthcare Reimbursement Account

Annual Maximum: $3,200.00

☐ I elect to contribute $_____ ***per pay period*** (before taxes), which is $_____ ***per year***, to fund my account for reimbursement of qualified healthcare expenses not covered under my health and other insurance plans.

☐ I decline to participate in this option for this plan year.

Rollover to 2024: $610.00

Option II: Dependent Care Reimbursement Account

☐ I elect to contribute $_____ ***per pay period*** (before taxes), which is $_____ ***per year,*** for funding reimbursement of qualified dependent care expenses.

Maximum amount per calendar year is the lesser of:

(1) $5,000 for married filling joint or $2,500 for married filling separate;
(2) your spouse's total annual compensation; or
(3) ½ of your total annual compensation.

If you are single, the maximum amount is $5,000.

☐ I decline to participate in this option for this plan year.

Option III: Waiver of Tax Benefits

☐ I have been given the opportunity to enroll in these tax-savings plans and have declined to participate. I understand that I will lose all tax savings that I may have received as a participant.

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash. I acknowledge that I have received, read and understand the Summary Plan Description.

Employee Signature _____ **Date** _____