People Lease
Payroll • Benefits • Compliance

ENROLLMENT PERIOD/PLAN YEAR: JANUARY 1, 2024 THROUGH DECEMBER 31, 2024

FLEXIBLE SPENDING PLAN ELECTION

EMPLOYER NAME: _____

Employee Name: _____ Date of Birth: _____

Address: _____

Marital Status: _____ Sex: _____ Contact Phone: _____

☐ I decline to participate in the employer sponsored Flex Plan. I have been given the opportunity to participate, and the benefits of the Plan have been explained to me. I understand that I may only participate at the beginning of the next **Plan Year**.

☐ I elect to participate in the employer sponsored Flex Plan. I agree to and understand that:

Elections cannot be changed during the Plan Year unless there is a change in the family status (marriage, divorce, death of a spouse or child, birth or adoption of a child or a change in spouse's condition of employment: i.e., becomes employed, unemployed, or changes employers).

Salary reduction for the Medical and Dependent Care Expense Reimbursement programs will be credited to my "Flexible Spending Account" and the employer will reimburse me during the Plan Year as I submit paid documentation for incurred expenses, for approved un-reimbursed medical and/or dependent care expenses. I further understand that any amount remaining in my "benefit bank" as of March 202 will be forfeited to the employer.

The opportunity to change my benefit elections for the following Plan Year will be given to me prior to each Plan Year. ***Benefit selections will continue from one Plan Year to the next without completing a new election form.*** However, if I wish to make a change or decline further participation for the next Plan Year, a new election form is required.

The employer may have to reduce or cancel the amount of my salary reduction or otherwise modify this agreement to satisfy new provisions of the Internal Revenue Code as they may occur during the plan year. Should I terminate my employment and the reimbursements I have received are greater than the amount that has been deposited into my Flexible Spending Account, I agree to reimburse the difference to People Lease.

Having selected the benefits checked below, I hereby elect to be reimbursed for the indicated expenditures and authorize my employer to reduce my gross compensation per pay period in the total amount stated below in conformity with Section 125 of the Internal Revenue Code.

Un-reimbursed Medical/Dental/Vision Expenses *(Not to exceed $3,200 for the 2024 Plan Year)* $_____

Dependent Child Care Expenses *(Not to exceed $5,000 for the 2024 Plan Year)*

Employee Signature: _____ Date:_____

**************************************FOR OFFICE USE ONLY**************************************

Total number of pay periods remaining in 2024 (12, 24 or 48)

Divide the Total Annual Eligible Expenses amount by the number of pay periods in 2024 to get your pay period election.

$_____(*Deducted per period/Medical*)
$_____*(Deducted per period/Dependent care)*