Missouri State Employees' Cafeteria Plan
Election Agreement
Plan Year 2019

MoCafe

ATTN: New employees must enroll using SEBES (https://www.sebes.mo.gov).

I wish to have my salary redirected from the first day of ________, 2019 through December 31, 2019 in each of the categories below. I am enrolling due to the following event: ____. This agreement is subject to the terms of the Missouri State Employees' Cafeteria Plan, Flexible Medical Benefits Plan, and/or Dependent Care Assistance Plan, and revokes any prior election under these plans.

NAME (Last, First MI)		SOCIAL SECURITY NUMBER	
HOME ADDRESS		AGENCY/ORG or UNIVERSITY	
EMAIL ADDRESS		PHONE NUMBER	

Section A: Premium Only Participation: POP
If you select to cancel pre-tax insurance premiums, it will not cancel your coverage. It will, however, mean that you will pay Federal and State Income taxes, and FICA taxes on all insurance premiums. **If you leave these boxes blank, all of your qualified insurance premiums will automatically be deducted pre-tax, saving you 25% or more on these expenses.** Please note that there is a **$.24** per month administrative fee if you do not cancel the POP.

Health Insurance (State-sponsored only)	Check here if you wish to **pay taxes** on your health insurance premiums: ______
Dental Insurance (State-sponsored only)	Check here if you wish to **pay taxes** on your dental insurance premiums: ______
Vision Insurance (State-sponsored only)	Check here if you wish to **pay taxes** on your vision insurance premiums: ______

Selecting "Cancel" does not cancel your insurance coverage or payment.

Section B: Flexible Spending Accounts: FSA (Elections for all categories in this section will terminate at the end of each year unless you re-elect for the following year.) **Do not put insurance deductions here!**

You can enroll in either the Health Care FSA or the Dental & Vision FSA – not both.

Category	Deduct this amount from each paycheck	# of paychecks in 2019	Annual Amount
Health Care FSA – annual amount cannot exceed $2,650	$.		$, .
Dental & Vision FSA – annual amount cannot exceed $2,650 (compatible with HSA)	$.		$, .
Dependent Care FSA – annual amount cannot exceed $5,000 (covers child/adult care expenses)	$.		$, .

☐ **DIRECT DEPOSIT:** I authorize Central/ASI to credit my account number ________________________________ with (name of bank) ______________________________________, routing number _ _ _ _ _ _ _ _ _ with my FSA payments. This account is a ______________(checking, savings, money market) account. If necessary, Central/ASI may make deductions from my account for any payments credited to my account in error. Please attach a copy of a voided check. My administration fee will be **$2.80** per month for Section A & B combined.

☐ Send a notice of payment with each direct deposit to the email address listed above. ☐ Do not send payment notices to me.

☐ Send notices of account activity via text messages to my cell phone. Please be aware that standard texting charges may apply, depending upon your cell phone plan. My cell phone number is: ___________________________ My mobile carrier is: ____________________

☐ **CHECK:** I wish to have a check mailed to me for my FSA payments instead of direct deposit. My administration fee will be **$4.00** per month for Sections A & B combined.

I have received the 2019 **MoCafe** Enrollment Guide and understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand that during the above period, this agreement is irrevocable and cannot be changed except under special circumstances (see Change in Status Events) as outlined in the Enrollment Guide. I hereby agree to have my pay reduced by the amount(s) specified above. I also agree to pay the applicable administrative fees through payroll deduction. I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in the Plan through the end of the Plan Year (inclusive of any applicable Grace Period) or the end of my coverage period if I terminate during the Plan Year. All reimbursement requests must be postmarked by April 15, 2020 in order to be reimbursed. I further understand that any unclaimed amount remaining in my flexible spending accounts after that date will be forfeited.

Employee's signature: ____ Date: ____________________

Please note: If you enrolled for the Health Care FSA or the Dental & Vision FSA, you have the option of obtaining a debit card to access your funds. If you wish to obtain a debit card, you will need to complete a debit card application form. You can do this either through the online enrollment process or through your account detail login once you become a participant.

NO CLAIMS ARE REIMBURSED PRIOR TO FEBRUARY 1, 2019!

CP-EF(09/18) Return this form to **MoCafe.** Fax to: 573-442-4435 or Mail to: PO Box 858, Columbia MO 65205-0858