



EMPLOYEE REIMBURSEMENT ACCOUNT PROGRAM

January through December 2014 Enrollment Form

Open Enrollment Deadline: December 8, 2013

EMPLOYEE INFORMATION:

Employee ID		Plan Year	01/01/2014 to 12/31/2014
Name		Effective Date	01/01/2014
Address		Deduction Begin Date	01/10/2014
City, State Zip		Date of Hire	
Daytime Phone		Date of Birth	
E-mail Address		Employee SSN	

EXTENSION PERIOD:

Wayne County's plan includes the IRS extension period. The extension / grace period allows for reimbursement of claims incurred within the first 2 ½ months of the next plan year using any funds remaining from the previous plan year. Thus, claims incurred during the period beginning January 1st through March 15th and submitted by March 31st of any given year may be reimbursed with any unused funds remaining in your account from the previous plan year.

TERMS OF ENROLLMENT:

- As an eligible participant in the Cafeteria Plan, I acknowledge that I have received the Employee Reimbursement Account Summary Plan Description (SPD). I have read the SPD and understand the benefits available to me as well as the other rights and obligations that I have under the Plan. In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the plan year or during such portion of the year as remains after the date of this agreement.
- I understand that reimbursements will be available only for qualifying expenses as described in the SPD specifically for each benefit I have elected herein. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate at the end of the stated plan year, upon termination or discontinuation of the Plan, or if I cease to receive compensation from the Employer which, before redirection hereunder, is a least equal to the amount of the redirection.

OTHER TERMS AND CONDITIONS:

- I understand that I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he/she believes it to be advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements or benefit plans.
- The amount of my compensation redirection(s) will be credited to an insurance, health care, dependent care, adoption, parking, and/or commuter transit / van pool expense reimbursement account and such amount will be paid on my behalf or I will be reimbursed, up to the amount which I have elected to redirect to the Cafeteria Plan, for the applicable expenses incurred during the year.
- Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year except as provided for during the IRS extension period described previously.
- My Social Security benefit may be slightly reduced as a result of my election.
- I hereby consent to the use of my personally identifiable information, and or my dependents' information, which I have voluntarily provided in this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, or my dependents' behalf, for the sole purpose of providing benefits, services, or any information I have requested.

REIMBURSEMENT PROGRAM ELECTIONS:

REIMBURSEMENT BENEFIT ELECTION TYPE	MAXIMUM ELECTION AMOUNT ALLOWED	AMOUNT OF ANNUAL COMPENSATION REDIRECTION	NO. OF PAYS REMAINING IN PLAN YEAR	AMOUNT TO BE DEDUCTED PER PAY (Annual Amount divided by Remaining Pays)
Health Care	\$2,500 per year	\$	26	\$
Dependent Care	\$5,000 per year	\$	26	\$
Parking at Work*	\$240 per month	\$	26	\$
Commuter Transit*	\$125 per month	\$	26	\$

DESIGNATION OF BENEFICIARY: In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

ORDER	BENEFICIARY NAME	RELATIONSHIP	PHONE NUMBER
Primary Beneficiary			
Secondary Beneficiary			

DEBIT CARD(S): Debit cards are available for participants enrolled in a Health Care Expense Reimbursement Account.** Indicate if you wish to have the card(s) sent to you, your spouse and college-aged child(ren).

CARD HOLDER	ISSUE DEBIT CARD** (YES / NO)	NAME
Employee		
Spouse		
Child		
Child		

** An annual debit card fee of \$12.50 per participant (employee) will be charged against account.

RETURNING COMPLETED FORM: Completed forms must be submitted by deadlines indicated within this form or by the Plan Administrator to the address / fax number indicated below. For additional information, contact the Benefits Administration Division at 313-224-7721 or via email to benefits@co.wayne.mi.us.

Mail: Benefits Administration Division, 500 Griswold Street – 9th Floor, Detroit, MI 48226
Fax: 313-967-1228

AMENDED ELECTIONS: Elections may be amended prior to the submission deadlines. If you have previously submitted an election form and this submission is a replacement of the previous election, please check below.

- The elections indicated on this form are to replace previously submitted elections for the plan year for which this form was intended. All previous are to be disregarded.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN AND/OR HEALTH CARE, DEPENDENT CARE, ADOPTION, PARKING AND COMMUTER TRANSIT / VAN POL EXPENSE REIMBURSEMENT PLANS, AS AMENDED FROM TIME TO TIME, IN EFFECT AND SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES AN PRIOR ELECTION AND COMPENSATION REDIRECTION AGREEMENT RELATING TO SUCH PLAN(S).

Employee Signature: _____ **Date:** _____

Accepted and agreed to by the Wayne County P/HR Benefits Administration Division authorized representative:

By: _____ **Date:** _____