# MISSISSIPPI AUTHORITY FOR EDUCATIONAL TELEVISION
## CAFETERIA PLAN ELECTION MENU

Name _____ Social Security No. _____

## BASIC PLAN

Eligible Coverages

| | | | |
|---|---|---|---|
| State Health | $_____ | Cancer/ICU (Humana) | $_____ |
| State Life | $_____ | Cancer/ICU (Central United) | $_____ |
| Dental (Delta) | $_____ | Accident (UNUM) | $_____ |
| Vision (Superior Vision) | $_____ | Aflac_____ | $_____ |

## PARTICIPATION AGREEMENT

I understand that all eligible benefit coverages offered by the above mentioned employer are available to me through payroll deduction under my employer's Pre-Tax Benefit Plan as provided under Section 125 of the Internal Revenue Code. I elect to purchase benefits under the plans that I have elected to enroll in as indicated above and authorize premiums to be paid on my behalf equal to my contributions for such insurance. I understand that selection of new insurance coverage does not automatically provide coverage and I must complete an application for insurance. I understand that any changes in premium by an insurance company will automatically adjust the amount of my salary reduction. I understand that any election made under the Cafeteria Plan herein is irrevocable and may be changed only as of January 1st of each year or in the event of a change in family status (i.e., a change in marital or dependent status, death of a family member, or a spouse's change in employment status or other change allowed by the I.R.S.) Finally, if I later choose not to participate in the Cafeteria Plan or wish to change the plans under which I am covered, I may change such election made herein only as of the January 1st following the date this election is made. I also understand that if changes are not made by January 1st, I will be treated as having continued the same elections in effect for subsequent plan years (January 1st, - December 31st). I am aware that any expenses paid through the Cafeteria Plan are no longer eligible as deductions for federal or state income tax purposes and participation may reduce my future social security entitlements.

_____ _____

Signature of Employee Date

## FLEXIBLE SPENDING ACCOUNT

MEDIFLEX $_____ per month CAREFLEX $_____ per month

## FLEXIBLE SPENDING ACCOUNT AGREEMENT

I hereby elect to participate in a flexible spending reimbursement plan offered as an option under the Flexible Benefit Plan of the above mentioned employer for the Plan Year beginning January 1st, and ending December 31st. I understand that expenses can be **incurred** until March 15 of the next year and be claimed for this Plan Year.

(a) I understand that I must submit a Reimbursement Claim itemizing the Expenses to be reimbursed, and include supporting evidence as set forth in the Plan.

(b) I understand that the expenses must be **incurred** within the Plan Year noted above or until the end of my eligibility, regardless of when I actually paid the expense.

(c) I understand that if I do not claim the total balance in my account by May 15th after the end of the Plan Year, or within 60 days after the end of my eligibility, I will forfeit my right to the remaining balance in the account.

(d) I understand that my employer will reimburse me for non-reimbursed medical expenses up to the amount that has been incurred during the Plan Year not to exceed my Plan election.

_____ _____

Signature of Employee Date

## WAIVER FOR PARTICIPATION

I understand that all benefit coverages now offered by the above mentioned employer through payroll deduction are available to me under the above mentioned employer's Cafeteria Plan and that the effect of Plan participation is to reduce the cost of these benefit coverages to me. I have been offered the opportunity to participate in this Plan and do hereby decline this opportunity and elect to receive current compensation. I understand if changes are not made by January 1st, I will be treated as having continued the same elections in effect for subsequent plan years (January 1st, - December 31st).

_____ _____

Signature of Employee Date