Pinnacle | Health & Benefits

Election to Participate Form

General Information

Employee Name (First, Middle, Last)	Employee Email Address	
Employee Telephone Number (###) ### ####	Munis No	Date of Birth* (Month/Day/Year)
Employee Mailing Address		Date of Hire* (Month/Day/Year)
Pay Group	☐ Certified (paid the 5th of each month). Deduction will be taken 10 times per year. ☐ Administrators (paid the last day of each month). Deduction will be taken 10 times per year. ☐ Classified (paid bi-weekly). Deduction will be taken 20 times per year.	

Benefit Accounts

Annual Contribution and Compensation Reduction Agreement

The Company and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each period during the plan year (or during such portion of the year as remains).

Health Flexible Spending Account (FSA)

☐ I elect to contribute $_____ per pay period ☐ I decline Health FSA coverage

$_____ annually

*2023 Maximum FSA election is $3,050.

Dependent Care Flexible Spending Account (FSA)

☐ I elect to contribute $_____ per pay period ☐ I decline DCAP FSA coverage

$_____ annually

*2023 Maximum Dependent Care FSA election is $5,000 single/married filing jointly ($2,500 married filing separately).

AUTHORIZATION: Please read the following statements and then sign and date this form. I authorize the reduction of my salary on a per paycheck basis, by the amount designated above. I understand that the amounts deducted from my pay and not used for eligible health care or dependent care expenses incurred in the same year will be forfeited in accordance with IRS regulations.

I understand that this authorization is irrevocable until the next election period unless I have a change in status.

I also understand that this agreement is subject to the terms of the Company's Cafeteria Plan, Healthcare Reimbursement Plan and/or Dependent Care Assistance Plan as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take this as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan (s). I further declare that I will not deduct these expenses on my federal income tax return.

_____ _____

Employee Signature Date

Waiver of Participation

I decline to participate in the Health or Dependent Care Spending Accounts for the current plan year.

_____ _____

Employee Signature Date

Please return this form to the Benefits Office at Central Services Gracey or amy.wigington@cmcss.net.