



**FLEXIBLE BENEFITS PLAN**  
**Plan Year (July 1, \_\_\_\_\_ – June 30, \_\_\_\_\_)**

Section 125 of the Internal Revenue Code established the ability for employees to pay for their Health Insurance, Personal Life Insurance (Prudential only), Dental Insurance, and/or Vision Insurance premiums on a pre-tax basis. Employees who participate in the premium only plan pay fewer taxes, and show less “wages, tips and other compensation” on their W-2. See the reverse side for the terms and conditions. For a complete description of the plan, see our website at [http://www.lsuagcenter.com/en/administration/about\\_us/Human\\_Resources/Benefits/Insurance/Tax+Saver+Flexible+Benefits+Plan.htm](http://www.lsuagcenter.com/en/administration/about_us/Human_Resources/Benefits/Insurance/Tax+Saver+Flexible+Benefits+Plan.htm).

PREMIUM ONLY – No participation fee	
<input type="checkbox"/>	<b>YES</b> , I elect to participate in the Premium only portion of the Flexible Benefits plan. I understand that this election will remain in effect and cannot be cancelled or changed during the plan year unless the cancellation or change is within the guidelines of the Louisiana State University System’s Flexible Benefits Plan.
<input type="checkbox"/>	<b>NO</b> , I DO NOT elect to participate in the Premium only portion of the Flexible Benefits plan. I understand that this election will remain in effect and cannot be cancelled or changed during the plan year unless the cancellation or change is within the guidelines of the Louisiana State University System’s Flexible Benefits Plan.

Section 125 of the Internal Revenue Code also established the opportunity for employees to pay certain health care expenses (those for which reimbursement is not received from an insurance carrier) and dependent care expenses with tax-free dollars. The employee determines the amount to deposit in either or both of the two accounts. The monthly amount indicated is deducted in equal installments from the employee’s paychecks during the plan year. See the reverse for the terms and conditions.

SPENDING ACCOUNTS - \$5.05 per month participation fee	
<p align="center"><u>HEALTH CARE SPENDING ACCOUNT</u></p> <p><input type="checkbox"/> <b>YES</b>, I choose to participate in the Health Care Spending account (Annual Maximum = \$4,000 per year; Annual Minimum = \$100 per year. <i>Amount to be prorated for the amount of the plan year actually enrolled.</i>)</p> <hr style="border-top: 1px dashed black;"/> <p>Per Pay Check Contribution \$ _____  <i>Amount must be a whole number.</i></p>	<p align="center"><u>DEPENDENT CARE SPENDING ACCOUNT</u></p> <p><input type="checkbox"/> <b>YES</b>, I choose to participate in the Dependent Care Spending account (Annual Maximum = \$5,000 per family or \$2,500 if married filing separately, per year; Annual Minimum = \$100 per year. <i>Amount to be prorated for the amount of the plan year actually enrolled.</i>)</p> <hr style="border-top: 1px dashed black;"/> <p>Per Pay Check Contribution \$ _____  <i>Amount must be a whole number.</i></p>
<p>I understand that the per pay check contribution amount that I have designated above will be multiplied by the number of paychecks that I receive annually: 9; 12; 24; other. (Employees who are paid biweekly usually have 26 paychecks; However, the spending account contribution is only deducted from 24 of the 26 paychecks.) ***<i>Monthly rate will be pro-rated by number of paychecks remaining in the year with a restricted amount of \$333/month for 12 month employees and \$444/month for 9 month employees</i>***</p>	
<p>By participating in the Spending Account(s), I understand that:</p> <ul style="list-style-type: none"> <li>• I agree to pay an administrative fee for participating in the HC and/or DC plan(s) in the amount of \$5.05 per month.</li> <li>• My elections for the period cannot be changed unless I incur a change in family status (see reverse).</li> <li>• Any money remaining in my account(s) at the end of the plan year will be forfeited (IRS: Use it or lose it rule).</li> <li>• The deductions I have elected are made in accordance with the Louisiana State University System’s Flexible Benefits Plan.</li> </ul>	
<p><input type="checkbox"/> <b>NO</b>, I DO NOT elect to participate in the Health Care Spending Account.</p>	<p><input type="checkbox"/> <b>NO</b>, I DO NOT elect to participate in the Dependent Care Spending Account.</p>

This agreement will remain in effect for the Plan Year unless changed for reasons stated in the terms and conditions of the Plan on the back of this form. By affixing my signature below, I certify that I have examined this agreement and understand and agree to comply with the terms and conditions of the Plan. I agree to hold Gilsbar and my employer harmless from any liability to my participation in this plan.

Printed Name: \_\_\_\_\_ LSU ID # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

You will receive a debit card for use at approved doctor’s offices, hospitals, pharmacies, etc. If you do not wish to use the debit card, your reimbursements can be direct deposited into an account of your choice. You must complete a direct deposit authorization form. This form can be found on the AgCenter HRM website at [http://www.lsuagcenter.com/en/administration/about\\_us/Human\\_Resources/Benefits/Insurance/Tax+Saver+Flexible+Benefits+Plan.htm](http://www.lsuagcenter.com/en/administration/about_us/Human_Resources/Benefits/Insurance/Tax+Saver+Flexible+Benefits+Plan.htm).

**RETURN THIS FORM TO THE LSU AgCenter HRM OFFICE NO LATER THAN 30 days FROM THE DATE OF YOUR APPOINTMENT.**  
P.O. Box 25203 Baton Rouge, LA 70894 or Room 103 J.N. Efferson Hall, LSU Campus, Baton Rouge, LA 70803

Employer’s use Only	
Deduction Begin Date _____; Deduction End Date _____; Payroll Type _____; Annual Target _____; Certified by _____.	

- New Enrollment
- Account Change

**FLEXIBLE SPENDING ACCOUNT  
AUTHORIZATION AGREEMENT  
FOR DIRECT DEPOSIT**

I am currently participating in the Flexible Benefits Plan, Health Care and/or the Dependent Care Spending Account(s) and would like my checking or savings account to be on file for claim reimbursements to be deposited directly. I understand that this process will take up to 10 business days from the date Gilsbar receives this form for this enrollment/change to become effective.

Employer Name: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Participant LSU ID #: \_\_\_\_\_

I hereby authorize Gilsbar, Inc., to deposit any amounts owed me, by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Gilsbar, Inc. to my account. In the event that Gilsbar, Inc. deposits funds erroneously into my account, I authorize Gilsbar, Inc. to debit my account for an amount not to exceed the original amount of the erroneous credit.

Name: \_\_\_\_\_

Bank Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please change my account to:

Transit/ABA #: \_\_\_\_\_ Account #: \_\_\_\_\_

(Please provide the Transit/ABA number that is on your check, not on the deposit slip. You may also attach a voided check below.)

- Checking       Savings

This authorization is to remain in full force and effect until Gilsbar, Inc. has received written notification from me of its termination in such time and in such manner as to afford Gilsbar, Inc. and the Bank a reasonable opportunity to act on it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Memo \_\_\_\_\_

\_\_\_\_\_ AUTHORIZED SIGNATURE

⑆ 123456789 ⑆ 123456789 ⑆ 0101

Transit/ABA #  
(A 9 digit number always between  
these two marks)

Checking Account #

## TERMS AND CONDITIONS

By signing the front of this election form, I understand that:

The **Premium Only election** on the reverse of the form **will automatically renew each plan year**, which begins July 1, and will be binding unless I revoke them and make a new election during an April annual enrollment period, and that the **Spending Accounts must be re-elected each plan year**. All changes must be made in accordance with the guidelines established in the Louisiana state University System Flexible Benefits Plan and Section 125 of the Internal Revenue Code.

I will need to complete a separate direct deposit authorization form in the event I wish to have my reimbursements directly deposited into an account of my choice. This form can be found on the AgCenter Human Resources Management website at

[http://www.lsuagcenter.com/en/administration/about\\_us/Human\\_Resources/Benefits/Insurance/Tax+Saver+Flexible+Benefits+Plan.htm](http://www.lsuagcenter.com/en/administration/about_us/Human_Resources/Benefits/Insurance/Tax+Saver+Flexible+Benefits+Plan.htm).

The dependent day care expenses and out-of-pocket medical expenses that qualify under Section 125 of the Internal Revenue Code are separate flexible benefit accounts. My contributions to and expenses incurred for each flexible benefit account are separate and non-transferable from one account to another.

I will be reimbursed for out-of-pocket medical expenses at any point during the Plan Year up to the amount of my Plan Year election. Dependent day care expenses will not be reimbursed in excess of the amount in my flex account. Reimbursements will be mailed to the address listed on the front of this election form unless I elect to have them direct deposited into the account of my choice. (Please refer to the Direct Deposit Authorization form for more details.) I understand that it is my responsibility to notify my employer and Gilsbar should I incur a change of address.

In order to change my election after the Plan Year has begun, I must experience a qualified Change in Status Event. Election changes due to a Change in Status Event must be made within a reasonable time (30 days before of after the event unless otherwise specified in my Summary Plan Description) AND must be consistent with the change that took place as defined by the IRS Consistency Rule. The effective date of the election brought forth by the Change in Status Event is the later of the: (1) date of the change in Status Event, or (2) the date you requested the change, except for the birth or adoption of a child where HIPAA special enrollment rules apply. The following chart outlines the qualifying Change in Status Events:

<p style="text-align: center;"><b>Events for employer-sponsored health-related and group term life insurance plans and the out-of-pocket Health Care Spending Account (Health Insurance, Prudential Life (employee only), Dental, and Vision Insurances)</b></p> <p><b>Change in Status – Qualifying Events</b></p> <ol style="list-style-type: none"><li><b>1. Change in Legal Marital Status:</b> Marriage, divorce, death of spouse, legal separation, and annulment.</li><li><b>2. Change in the number of tax dependents:</b> Birth, adoption, placement for adoption, and death of a spouse or dependent</li><li><b>3. Change in employment status of the employee, employee’s spouse or employee’s dependent(s):</b> Termination or commencement of employment, strike or lockout, commencement of, or return from an unpaid leave of absence, a switch between part-time and full-time employment, or a change in worksite.</li><li><b>4. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements:</b> Due to attainment of limiting age under the insurance plan, gain or loss of student status, marriage or any similar circumstance.</li><li><b>5. Residence change of the employee, employee’s spouse, or employee’s dependent(s):</b> Only allowable if the change in residence affects the employee’s eligibility for coverage.</li></ol>
<p><b>Consistency Rule:</b></p> <p>In order to change my election, the change must be on account of and correspond with a Change in Status Event that affects me, my spouse or my dependent’s eligibility for the employer-sponsored benefit plan(s). In other words, the increase or decrease in my flexible benefit plan election amount must be consistent with the gain or loss of my eligibility to participate. If the Change in Status Event does not affect the eligibility of my insurance and/or out-of-pocket medical expense I cannot make the change. Special consistency rules also apply for the following situations: loss of dependent eligibility, gain of coverage eligibility under another employer’s plan, and life or disability coverage. Should I need further clarification of these events, I should contact Gilsbar using their phone number: 1-800-445-7227 ext 883.</p>
<p><b>Additional Change in Status – Qualifying Events</b></p> <p>Cost changes with automatic election increases/decreases, *significant cost increases, *significant coverage curtailment, *addition or elimination of benefit package options offered by my employer, *change in coverage of spouse or dependent under another employer’s plan, *Family Medical Leave of absences as qualified under FMLA, HIPAA special enrollment rights, qualification and election under COBRA or state continuation, *Medicare or Medicaid entitlement or curtailment, or a judgment, decree or court order including a Qualified Medical Child Support Order.</p> <p>*Does not apply to the Health Care Spending Account.</p>
<p style="text-align: center;"><b>Events for Dependent Day Care Account</b></p> <p>Marriage, divorce, death, birth or adoption of a child of the employee, termination or commencement of employment of the employee’s spouse, a switch between full-time and part-time by the employee or employee’s spouse, taking an unpaid leave of absence or returning from an unpaid leave of absence by the employee or employee’s spouse, going on or returning from a Family Medical Leave of absence as qualified under FMLA.</p>

The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event it believes the reduction or cancellation is advisable in order to satisfy certain provisions of the Internal Revenue Code. Prior to each Plan Year I will be given the opportunity to change my Flexible Benefit Plan Election for the upcoming year.

My election of benefits shall cease upon termination of my employment. If my Employer is subject to COBRA, I may continue my out-of-pocket medical participation with after-tax contributions, if I so elect, pursuant to my rights under COBRA. If I do not elect COBRA for my flexible spending account(s), my benefits are limited to the time from which the Plan Year began and my last day of employment.

My social security benefits may be affected because I am lowering my taxable income by electing to participate in the Flexible Benefit Plan. This means that my Social Security benefits could be decreased because of the decreased amount of compensation which is considered for Social Security purposes. In most cases, my Flexible Benefit Plan election will not affect any other benefits I receive from my Employer. However, paying for disability income policies pre-tax will cause the benefits payable thereunder to be taxable.

To receive these tax-free benefits, I must plan ahead. Planning is important because the IRS says that I will lose any unused money in my flexible spending account(s) at the end of the Plan Year filing period. Any claims submitted after that time cannot be considered. Any monies forfeited may not be paid back to me in any manner or used to provide future benefits, according to IRS regulations.