



MedBen Group # _____

COMPENSATION REDIRECTION AGREEMENT

New Election Change in Status (Form 1101 must accompany this request)

Name: Last, First, Middle Initial _____ Social Security Number _____

Street Address _____

City _____ State _____ Zip Code _____

Branch/Department _____ Date of Employment _____

PREMIUM ONLY PAYMENT ACCOUNT (Premium Only Payment)

Health Insurance Premium \$ _____
Dental Insurance Premium \$ _____
Vision Insurance Premium \$ _____
Total Per Pay Contribution \$ _____
Total Annual Contribution \$ _____
(Total Contribution for the Plan Year)

HEALTH CARE SPENDING ACCOUNT (Employee and/or Dependent Medical, Dental, Eye Care Expenses - not reimbursed by Insurance)

Per Pay Contribution \$ _____
Total Annual Contribution \$ _____
(Total Contribution for the Plan Year) (\$ _____ Maximum)

DEPENDENT CARE SPENDING ACCOUNT (ONLY work-related child and/or Adult Day Care Expenses)

Per Pay Contribution \$ _____
Total Annual Contribution \$ _____
(Total Contribution for the Plan Year) (\$5,000 Maximum; \$2,500 if married and filing separate income tax return)

DECLINE PARTICIPATION IN THE PRE-TAX CONTRIBUTION

I hereby elect not to participate in the pre-tax contribution option. I understand I will not have another opportunity to enroll until the next annual enrollment period.
DO NOT CHECK THIS BOX IF YOU HAVE COMPLETED THE ABOVE.

LATE HIRES – NUMBER OF PAY CYCLES REMAINING IN PLAN YEAR: _____ For Office Use Only
LATE HIRES – EFFECTIVE DATE ON PLAN: _____ For Office Use Only

Read the statements below. Then, sign and date this form.

I have received and read a copy of the "The Employees Guide to Health and Dependent Care Spending Account". I understand that the amounts deducted from my pay and not used for eligible health care and/or dependent care expenses incurred within the same year **will be forfeited** in accordance with IRS regulations. I also understand that this authorization is irrevocable until the next election period unless I have a change in family status as described in the "Employees Guide". Life event changes must be submitted to the Human Resources Department within the first 30 days of the effective date.

Signature _____ Date _____

Specialty Services Unit • 1975 Tamarack Road • P.O. Box 1096 • Newark, OH 43056-1096
COBRA Phone (800) 297-1849 • FSA/HRA Phone (800) 297-1829 • fax (740) 522-7483
www.medben.com • admin@medben.com