McIlveen PLLC
Premium Election Form

- ☐ Correction
- ☐ Change of personal information
- ☐ Change of Family Status
- ☐ Transfer
  Effective Date_____
- ☐ Termination
- ☐ Waive Participation _____ (initial)

Personal Information

Last Name	First Name	Middle Initial	Social Security Number

Home Address	Street	City	State	Zip

Date of Birth: / / Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married Date of Hire: / /

Benefit Elections (Circle coverage elected and enter appropriate amount on total cost per month line.)

(Employee Cost Per Month*)

Name of Benefit Plans To Be Offered	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____

* Amount after Employer contribution is deducted **Total Cost Per Month $_____**

Salary Reduction Agreement

I have read and understand the explanation I have received regarding my options under the McIlveen PLLC Premium Only Plan. I understand I have the right to have the company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the medical coverage I have designated above. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; a change in worksite; or any change in employment status that affects eligibility; a change in residence for me, my spouse or children; or my dependent either satisfies or ceases to satisfy requirements for coverage due to change in age, student status, or any similar circumstances; or a change in my or my spouse's employment status.

It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy. I understand that subsidized insurance premiums can only be deducted on a post-tax basis.

I hereby apply for the options listed above. If necessary, I authorize McIlveen PLLC to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from December 1 until November 30, unless my family status changes.

_____ _____
Employee Signature Date

_____ _____
Company Representative Date

MCILVEEN PLLC
HEALTH FSA ELECTION FORM

(Please Print)

1. PERSONAL DATA **PLAN YEAR**_____ Effective Date_____

Name_____ Waive Participation_____ (initial)
(Last) (First) (MI)

Marital Status:_____ Date of Hire_____ Soc. Sec. _____ - ___ -_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

Email _____ Work Phone_____Home/Cell Phone _____

I prefer to be contacted regarding my FSA Account via Email ____, Wk Ph____, Hm/Cell Ph_____, 1st Class Mail_____

DEPENDENT INFORMATION (Must List ALL eligible Dependents Affected by Enrollment)

Last Name	First Name	Relationship (Self/Spouse/Child)	M/F	SS#	Date of Birth
Employee		*Self*			
Dependent					
Dependent					
Dependent					
Dependent					

2. FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS

HEALTH FLEXIBLE SPENDING ACCOUNT - Employer Contribution ☐ NO ☐ YES $_____Annual Benefit

PAYROLL SCHEDULE ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

EMPLOYEE ELECTION $_____/Per Pay Period $_____/Annually (from your Effective Date until November 30)

TYPE OF PLAN: ☐GENERAL PURPOSE ☐LIMITED PURPOSE / POST DEDUCTIBLE ☐EMPLOYEE ONLY

3. AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs. Changes must be submitted within 30 days of the qualifying event.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits from my Insurance Provider, itemized bill, etc.) for out-of-pocket Medical, Dental, Vision expenses before I can be reimbursed.

I understand that the plan provisions will require that all Health FSA participants who have a positive balance (taking into account all claims submitted prior to termination) at the time of terminating employment will be provided with information regarding their COBRA options, if applicable (see your Summary Plan Description regarding COBRA qualifications). If the continuation for the Health FSA is not elected, I realize that I will not be reimbursed for any expenses incurred after the date employment terminates.

I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize McIlveen PLLC to make pretax deductions from my salary on the payroll schedule I have elected above. I understand that to stop such deduction, I must notify McIlveen PLLC Benefits office in writing with my request, and revoke this authorization.

Any unused dollars remaining in my Flexible Spending Account at the end of the year will be forfeited. Expenses/claims must be incurred during the time that I participate in the plan in order to be eligible for reimbursement.

Employee's Signature _____ Date: _____

MCILVEEN PLLC
HEALTH FSA
REIMBURSEMENT CLAIM FORM

PERSONAL DATA (Please Print)

Name	SS# (Last four digits only) X X X – X X –
Home Address	Address Change: ☐Yes ☐No
City	State / Zip
Phone: Work ( ) Home/Cell ( )	Email: I prefer to be contacted by Email, Wk Ph, Hm Ph, Mail (***circle one***)

You must provide a receipt showing the date of service, amount of service, description of service, name of service provider, and name of patient or other evidence the expense was incurred (such as an EOB from your Insurance Provider). If this form is incomplete your claim could be denied. Print or type the information requested, then sign and date the form.

	Name of Medical Provider (Doctor, Pharmacy, etc.)	Date Medical Care Provided*	Patient Name	Relationship (Self, Spouse, Child)	Amount that is your responsibility	General Medical Expense Description. (Must Attach Prescription for OTC Medication.)
1					$	
2					$	
3					$	
4					$	
5					$	
6					$	
7					$	
8					$	
9					$	
10					$	
		Total Medical Amount Requested →				$

Please arrange documentation in order listed above.

***Claims for future services will not be accepted**

I request payment from my **Health Flexible Spending Account** (FSA) as indicated above for the expenses listed. I certify that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while I was enrolled in the Employer's FSA with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I certify that these expenses will not be claimed as an income tax deduction. I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I authorize my FSA to reimburse me by the amount requested.

☐ **I am funding an HSA for this Plan Year** ☐ **I am NOT funding an HSA for this Plan Year**

Employee Signature_____ Date_____

SUBMIT YOUR COMPLETED CLAIM FORM TO:

Angela McIlveen
174 S. South St.
Gastonia, NC 28502

MCILVEEN PLLC
DEPENDENT CARE ASSISTANCE PLAN
ELECTION FORM

(Please Print)

1. **PERSONAL DATA** **PLAN YEAR**_____ Effective Date of Enrollment/Change _____

Name_____ Waive Participation_____ (initial)
(Last) (First) (MI)

Marital Status:_____ Date of Hire_____ Soc. Sec. _____ - ___ -_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

Email _____ Work Phone_____Home/Cell Phone _____

I prefer to be contacted regarding my FSA Account via Email ____, Wk Ph____, Hm/Cell Ph_____, 1st Class Mail_____

DEPENDENT INFORMATION (Must List ALL Dependents Affected by Enrollment)

Last Name	First Name	Relationship	M/F	SS#	Date of Birth
Dependent					
Dependent					
Dependent					
Dependent					

2. **FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS**

DEPENDENT CARE ASSISTANCE PLAN ☐YES ☐ NO $_____/Per Pay Period $_____/Annually

PAYROLL SCHEDULE ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

DEPENDENT CARE FSA CONTRIBUTIONS TO BEGIN ON _____ (*First Pay Date after Effective Date*)

3. **AUTHORIZATION AND ACKNOWLEDGEMENT**

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs.

I understand that I must submit a claim and appropriate documentation for out-of-pocket Dependent Care Expenses before I can be reimbursed.

I understand that the plan provisions will require that all DCAP participants who have a positive balance (taking into account all claims submitted prior to termination) at the time of terminating employment will be provided with information regarding their COBRA options, if applicable (see your Summary Plan Description regarding COBRA qualifications). If the continuation for the DCAP is not elected, I realize that I will not be reimbursed for any expenses incurred after the date employment terminates.

I hereby elect to participate in the Flexible Spending Account as indicated on this form. I authorize McIlveen PLLC to make pretax deductions from my salary on the payroll schedule I have elected above. I understand that to stop such deduction, I must notify McIlveen PLLC Benefits office in writing with my request, and revoke this authorization.

Any unused dollars remaining in your DCAP Flexible Spending Account at the end of the year will be forfeited. Expenses/claims must be incurred during the time that you participate in the plan in order to be eligible for reimbursement.

SIGNATURE_____ DATE_____

MCILVEEN PLLC
DEPENDENT CARE ASSISTANCE PLAN
REIMBURSEMENT CLAIM FORM

(Please Print)

1. PERSONAL DATA **PLAN YEAR**_____ SS# (Last four digits only) XXX-XX-_____

Name_____ Home Phone #_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

2. DEPENDENT CARE EXPENSES

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	age	Dates Care Provided		Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period
		From	To*		
		Total Dependent Care Amount Requested		→	

I provided the dependent care as stated above.

X_____ _____ _____

Care Provider's **original** signature Date SSN/Tax ID#

3. TERMS AND CONDITIONS

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her Employer's DCAP with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

_____ _____

Employee's Signature Date

SUBMIT YOUR COMPLETED CLAIM FORM TO:

Angela McIlveen
174 S. South St.
Gastonia, NC 28502

Notice: All employees participating in a Section 129 Dependent Care Assistance Plan are required to file Form 2441 with the IRS by April 15 of the year following your participation in this plan.

MCILVEEN PLLC
FLEXIBLE BENEFITS PLAN
CHANGE AND REVOCATION FORM

(Please Print)

PERSONAL DATA **PLAN YEAR**_____ Soc. Sec. #_____

Name_____ Home Phone #_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

CHANGE OR REVOCATION OF SALARY REDUCTION AGREEMENT

Please indicate the change in your Salary Reduction Agreement in the area below. If there is a status change event, change in cost/coverage or other-type change (judgment decrees, etc.) that is permitted under the Internal Revenue Code and Regulations, and which justifies a change in your Salary Reduction Agreement, you may change or revoke your Salary Reduction Agreement. However, once you make the change indicated on this form, you may not reinstate or revise your Salary Reduction Agreement as of a date before the first day of the next Plan Year unless there is another status change event, change in cost/coverage or other-type allowable change (judgments, decrees, etc.). Please Note: In most circumstances, you must submit the Change and Revocation Form within **30 days** of qualifying event.

Premium-type Benefits

If you are changing from one level of coverage, from single to family coverage for example, mark "Revoke" for your current coverage (e.g. single) and mark "New Enrollment" for the new coverage (e.g. family).

If you are ending participation in the Plan, mark "Revoke".

Current Election	Revoke/ Suspend	New Enrollment	Effective Date
** Health Insurance **			
[ ] Employee Only	[ ]	[ ]	__/__/__
[ ] Employee Plus Dependents	[ ]	[ ]	__/__/__
** Dental **			
[ ] Employee Only	[ ]	[ ]	__/__/__
[ ] Employee Plus Dependents	[ ]	[ ]	__/__/__
** _____ **			
[ ] Employee Only	[ ]	[ ]	__/__/__
[ ] Employee Plus Dependents	[ ]	[ ]	__/__/__

Flexible Spending Arrangements

If you are reducing or increasing your salary reductions, please indicate the new amount PER PAY PERIOD under "New Enrollment". If you are ending participation in the Plan, mark "Revoke".

Current Election	Revoke/ Suspend	New Enrollment Salary Reduction	Effective Date
[ ] Dependent Care FSA	[ ]	____.__	__/__/__
[ ] Medical Expense FSA	[ ]	____.__	__/__/__

Reason for Election Change – please mark [X] the appropriate election change event(s) that justifies the change(s) or revocation(s) on this form and enter the date(s) of the event(s)

1. Status Change Events

a. Change in Marital Status

[ ] Marriage on __/__/__
[ ] Divorce on __/__/__
[ ] Annulment on __/__/__
[ ] Legal Separation on __/__/__
[ ] Death of Spouse on __/__/__

b. Change in Number of Tax Dependents

[ ] Birth on __/__/__
[ ] Adoption on __/__/__
[ ] Other – Gain Tax Dependent on __/__/__
[ ] Death of Dependent on __/__/__
[ ] Death of Spouse on __/__/__

Reason for Election Change *(continued)*

c. Change in Employment Status With Gain or Loss of Eligibility -

Change relates to: [ ] *Employee* [ ] *Spouse or Dependent*

[ ] Termination of Employment on ___/___/___ [ ] Full-time to Part-time on ___/___/___
[ ] Commencement of Employment on ___/___/___ [ ] Part-time to Full-time on ___/___/___
[ ] Commencement of Unpaid Leave on ___/___/___ [ ] Return from Unpaid Leave on ___/___/___
[ ] Other (hourly to salary, union to non union, change in worksite, etc.) on ___/___/___

Provide Details: _____

_____

d. Change in Dependent Eligibility Under an Employer's Plan

[ ] Lost Eligibility (age, student status, attainment of age 13 for Dependent Care FSA, COBRA event, etc.) on ___/___/___
[ ] Gain Eligibility (e.g., age, student status, etc.) on ___/___/___

e. Change of Residence Affecting Eligibility – Date of change ___/___/___

Change relates to: [ ] *Employee* [ ] *Spouse or Dependent*

f. Commencement or Termination of Adoption Proceedings Date of change ___/___/___

(applies to Dependent Care FSAs only)

2. Special Enrollment Rights – HIPAA *(applies to Premium benefits only)*

[ ] Loss of other group health plan coverage on ___/___/___
[ ] Acquired new spouse or dependent (marriage, birth, etc.) on ___/___/___
[ ] Eligible for Premium Assistance Subsidy on ___/___/___

3. Certain Judgments, Decrees and Orders *(applies to Premium and Health FSA benefits only)*

[ ] Court order requiring coverage for Dependent on ___/___/___

4. Medicare or Medicaid *(applies to Premium and Health FSA benefits only)*

[ ] Became eligible for Medicare or Medicaid on ___/___/___
[ ] Became ineligible for Medicare or Medicaid on ___/___/___

5. Change in Cost *(applies to Premium and Dependent Care FSA benefits only)*

[ ] Significant cost increase in coverage on ___/___/___
[ ] Significant cost decrease in coverage on ___/___/___

6. Change in Coverage *(applies to Premium and Dependent Care FSA benefits only)*

[ ] Change in dependent care provider on ___/___/___
[ ] Significant curtailment of coverage on ___/___/___
[ ] Addition or significant improvement of a plan option on ___/___/___
[ ] Loss of group health coverage under plan of a governmental or educational institution on ___/___/___
[ ] Change in coverage under an Employer's plan on ___/___/___

Signature

I have examined this authorization to modify my Salary Reduction Agreement and to the best of my knowledge, it is true, correct and complete. I understand that the election change I have requested must be on account of and consistent with the status change or other election change event (s) I have checked above. I understand that the status and participation changes must comply with the Plan and that the Plan Administrator has the sole discretion in making this determination. I further understand that I may be required to provide documentation regarding the change(s) I have checked above.

_____ _____

Participant's Signature Date

Sec 132 and Sec 125 FSAs must indicate the LAST PAY DATE affected (may differ from actual Termination Date): ____/____/____

Denied by _____ on _____

Reason for Denial _____

Action to be taken _____

Plan Administrator _____ _____

Agreed and accepted by the Employer's Representative Date