

# MESSA OptionALL

## Medical / Dependent Care Flexible Spending Account

### ELECTION AND SALARY REDUCTION AGREEMENT FORM

Employee name \_\_\_\_\_  
*First*
*Middle*
*Last*

Address \_\_\_\_\_  
*Street*
*Apt. / lot #*

\_\_\_\_\_ *City* *State* *Zip code*

Social security number \_\_\_\_\_ Gender  male  female

Job title \_\_\_\_\_ Date of birth \_\_\_\_\_

School district where you're employed \_\_\_\_\_

Daytime telephone number \_\_\_\_\_

**BENEFIT ELECTION**

I am electing the following benefits:

- \_\_\_\_\_ Dependent Care Reimbursement Plan
- \_\_\_\_\_ Medical Reimbursement Plan

**ANNUAL EMPLOYEE CONTRIBUTION**

\$ \_\_\_\_\_  
 \$ \_\_\_\_\_

Number of pay periods \_\_\_\_\_ First payroll deduction date \_\_\_\_\_

**DEPENDENT INFORMATION**

First name	Middle initial	Last name	Social Security #	Relationship	Date of birth	Sex	F/T Student

I understand that this election will remain in effect in accordance with the rules and procedures of the MESSA OptionALL plan. I MUST complete a new Benefit Election form each plan year.

\_\_\_\_\_  
 Employee signature Date