"Plaza Towers Building"
1736 E. Sunshine Ste 200
Springfield, MO. 65804
417-883-8088 or 800-995-3569
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Cooper County Government

2021 Flexible Benefit Plan Enrollment Form

Employee Name (Last, First, M.I.) :				
Address:				
City:		State:	Zip:	Social Security Number:
Date of Birth:	☐ Male ☐ Female	☐ Single ☐ Married	Spouse Name:	Phone:

☐ **Yes, I do want to enroll in the reimbursement sections (fill out Worksheet below)**

The IRS regulation states four conditions such as

1. Any expenses you incur must be within the plan year.
2. Any expenses you incur must not be covered by any other source such as insurance.
3. You must provide proper documentation in order to receive payment
4. You cannot elect, change or revoke your election during the plan year unless there is a specific change in status and your employer allows such changes.

NOTE: Enrolling may have a minor effect on your social security and or retirement benefits. Please seek appropriate advice.

Healthcare Reimbursement Worksheet. I request the following amounts to be deducted pretax:

		Plan Year Total		# of Paychecks		$ per Pay Check
Medical Care Reimbursement: (Maximum $2,750.00)		_____	÷	_____	=	_____
Dependent Care Reimbursement: (Maximum $5,000.00)		_____	÷	_____	=	_____
	Totals:	_____	÷	_____	=	_____

☐ **No, I do not want to enroll in the reimbursement sections.**
If a change of status occurs, I may have the right to elect the plan at that time (if my employer allows).

Signature:_____**Date:**_____