UNITED ADMINISTRATIVE SERVICES

MEDICAL REIMBURSEMENT ACCOUNT
ELECTION FORM & COMPENSATION REDUCTION AGREEMENT

Employee Information					
Employee Name		Date of Birth		Social Security Number	
Employer Name		Phone		Email	
Employee Home Address		City		State	Zip
Check One:	☐ Single	☐ Married	☐ Married Filing Separately	☐ Widowed	☐ Legally Separated
Eligible Dependents:	1) Name: DOB:	2) Name: DOB:	3) Name: DOB:		

Pre-Tax Plan Election – I elect to receive the following benefits:

☐ Medical Reimbursement Account (MRA) – check with your employer for annual election maximum

Per Pay Period Contribution		Number of Pay Periods		Annual Election
$	X		=	$ 0.00

DESIGNATION OF BENEFICIARY

In the event of my death, my beneficiary may have certain obligations and responsibilities under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

Name _____ Relationship _____

Address _____

I elect to receive medical reimbursement for the plan year. I understand the following conditions:

Reimbursement will be available only for qualifying medical care expenses as described below. I agree to notify my employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse my employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

QUALIFYING MEDICAL EXPENSES

1. Only expenses **not** reimbursed by insurance can be claimed.
2. The reimbursement (when aggregated with all other reimbursements received by you under the Plan during the same year) may not exceed the maximum allowed under the Plan ($2,500.00).
3. Medical expenses (except participant's premium payment for other health coverage including premiums paid for health coverage maintained by the employer of the employee's spouse or dependent) which an individual could otherwise deduct on their Form 1040 Schedule A.

I hereby authorize my employer to withhold a service fee of $____ per pay period from my compensation for administrative cost of the Plan.

TERMS & CONDITIONS

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

Any unused dollars allocated to my Medical Reimbursement Account shall be forfeited as of the earlier of: (1) the last day of the Plan year, or (2) the date of my termination of employment with the Employer. I understand that I may submit requests for reimbursements within 90 days from the end of the Plan year or from the date of the termination, whichever is earlier. Only expenses incurred during the Plan year or prior to termination, whichever is earlier, are eligible for reimbursement.

AUTHORIZATION

My signature below certifies that I authorize my employer to make the appropriate payroll deductions to cover the above elections. My elections cannot be changed during the Plan year, unless I am eligible to make a change. I further understand that this form must be signed and dated prior to my Plan participation to be eligible in the Plan year. Any unused amounts remaining in my account at the end of the Plan year may be forfeited. Any previous election and agreement under the Plan relating to the same benefits, including any prior enrollment form/salary reduction agreement, is hereby revoked. I have read, understand and agree to all of the information indicated on the Plan descriptions.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF MY EMPLOYER'S MEDICAL REIMBURSEMENT ACCOUNT AS AMENDED FROM TIME TO TIME, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION AGREEMENT RELATING TO SUCH PLAN(S).

Employee's Signature	Date	
Approved by Employer's Authorized Representative	Date	Effective Pay Period