MDPC
Memorial Drive
Presbyterian Church

Section 125 Cafeteria Plan
Plan Election Form

FSA Administrator
10515 Saddlehorn Trail | Houston, TX 77064
Phone: 281-890-3042 | Fax: 281-970-2440

Plan Year

Participant S.S.N.

Address

Hire Date

Eligible Expenses	Per Pay Period
☐ Medical Insurance	$
☐ Dental Insurance	$
☐ Short Term Disability	$
☐ Long Term Disability	$
☐ Medical Care Reimbursement	$
☐ Dental Care Reimbursement	$
☐ Dependent Care Reimbursement	$

◉ I DO ○ DO NOT hereby authorize my employer to make periodic salary reductions from my paycheck, to be deposited in my account, for the election period specified above in an amount equal to the premiums required for the coverage elected above plus the specific dollar amounts, if any, elected for dependent care and/or health care reimbursement. The salary reductions shall be made in substantially equal amounts, to the extend administratively feasible. I further authorize FSA Administrator to disburse funds from my account in accordance with the plan and my elections. I understand that I must submit reimbursement requests to receive reimbursement from either my Dependent Care or Health Care Reimbursement Account. I understand that my elections, including coverage types, cannot be altered without a qualified change in family status.

I understand that all requests for reimbursement for expenses incurred during the plan year must be received by the FSA Administrator no later than 60 days following the plan year end.

_____ _____/_____/_____ _____
Signature of Participant Date Witness