JAG Professional Services, Inc.

SECTION 125 ELECTION FORM

Fax to **877-828-7319** *or email to* **payroll@jagprof.com**

PARTICIPANT INFORMATION

Please check if this is a new address ☐ Participant's Social Security #: _____- ____- _____

Name: _____
(Last) (First) (M.I.)

Street: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Daytime/Alternate Phone: _____

MEDICAL, DENTAL, OR VISION INSURANCE PREMIUMS

Plan Type *(Please check one)*	Provider Name	Coverage Year 2012 *Optional Start/End Months*		Monthly Premium
☐ Individual				$
☐ COBRA				$
			Total	$

When filing the claim forms for reimbursement under your (health, dental, and vision) insurance be sure to attach copies of statements from your insurance company, showing the date of premium and amount paid, a cancelled check, or credit card statement. **PLEASE NOTE: This is for Monthly Medical, Dental and/or Vision Premiums only**, **this is NOT a Flexible Spending Account.**

DEPENDENT/CHILD CARE CLAIMS

When claiming dependent care expense, please provide a written receipt of statement, including date and amount of expense incurred. (Handwritten receipts are acceptable for childcare.) Documentation will not be returned.

Effective January 1, 1989, the I.R.S. requires the dependent child care provider(s) to furnish the provider's current name, address, Tax Identification Number (or Social Security Number) to the tax payer making claim, unless the provider is exempt from federal income taxation as described in I.R.C. Section 501(c)(3). A provider failing to comply with this law is subject to $50 fine for each such failure unless proven that failure is due to reasonable cause, not willful neglect.

The dependent care information including provider(s) name, address, TIN/SSN is correct to the best of my knowledge. I understand I may incur penalties of perjury if the information is knowingly misstated.

Name of Dependent Receiving Care	Age (Yr)	Relationship	Provider Name & Address	TIN/SSN	Dates of Care	Requested Amount of Reimbursement

SALARY REDUCTION AGREEMENT

I have read and understand the explanation I have received regarding my options under the JAG Professional Services, Inc. Medical Benefit Plan. I understand I have the right to have the company make a deduction from my salary on a pretax basis during the plan year. 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 or adoption of a child; change in number of dependents; termination of employment or commencement of employment; commencement or return from an unpaid leave of absence; or any change in employment status that affects eligibility (a change in residence of you, your spouse or children; or your dependents either satisfies or ceases to satisfy requirements for coverage in age, student status, or any similar circumstances; or a change in your or your spouse's employment status).

I hereby apply for the options listed above. If necessary, I authorize JAG Professional Services, Inc. to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from January 1 until December 31, 2012 unless my family status or employment status changes.

_____ _____
Employee Signature Date

JAG PROFESSIONAL SERVICES FLEXIBLE BENEFIT PLAN SUMMARY

Advantages of the Plan

As part of our efforts to keep Medical Benefit and Dependent Care costs as affordable as possible, JAG Professional Services is pleased to sponsor the JAG Professional Services Flexible Benefit Plan. The plan provides each eligible employee with the opportunity to set aside part of his or her pay on a pre-tax basis to pay for (1) health, dental, or vision care benefit premiums, and/or (2) dependent care expenses. The plan is entirely voluntary, and it allows you to allocate pre-tax dollars from your paycheck. Any money allocated for these benefits is not taxed and the income we report to the IRS and state taxing authorities is your gross pay minus any of these deductions. In effect, your benefits are being subsidized to the extent of your marginal tax bracket (up to 39.3% in California). The Flex Plan allows you to customize a benefit plan to fit your exact needs by channeling taxable income into the non-taxable benefits of your choice.

Benefit Program

The benefits you may purchase fall into two categories:

1. Insurance Premiums (Medical, Dental, Vision, and Cancer Insurance)
   a. For a JAG Professional Services Sponsored Plan.
   b. Any insurance premium (health, dental, etc.) for you or your dependents may be paid through the 125 plan, including your existing insurance or a new insurance policy, providing you are the primary person insured on the policy.

2. Dependent Care
   Reimburses for care of your child or other dependent while you are at work. Specifications for this account are:
   a. Your child must be under age 13.
   b. Your dependent over age 13 must be incapable of self support.
   c. Individual caring for your child under age 13 must not be dependent upon you for support.
   d. Annual reimbursement cannot exceed the lower of $5,000 or your family's earned income.

How the Plan Works

All participants are required to determine the amount of their monthly deduction, if any, for each of the categories listed above. Participants are eligible to join the plan after completing one day of service at JAG Professional Services and must enroll during their first month of eligibility or wait until the next calendar year. **Once an amount is determined it cannot be changed until the following January unless you have a change in family status (marriage, divorce, birth or adoption of a dependent, death of a spouse or dependent, or loss of your spouse's employment).** It is important to estimate your expenses accurately (i.e.: increase or decrease in policy premiums). Under current tax laws, any money left in your account at the end of the year will be forfeited (use it or lose it).

The total elected amount is deducted once a month from one of your paychecks (usually the 2nd payday of each month) and placed in a reimbursement account. To receive money from your reimbursement account, you must file a claim form with supporting receipts showing you have spent money on eligible expenses (with the exception of automatic claim processing for employer sponsored insurance premiums). All claims are paid out of your reimbursement account and sent with your next paycheck.

Contributions made during any plan year can be used only for reimbursement of expenses incurred during that Plan Year. Expenses are incurred on the date services are provided. Reimbursement requests for a Plan Year must be received before March 31 of the following year. Any balance in your account after that date will be forfeited. Expenses reimbursed through these accounts are not eligible for tax deductions.