Section 125 Salary Reduction Agreement Enrollment Form

SC State Credit Union

Plan Year Beginning: 10/1/2020 Plan Year Ending: 9/30/2021

Employee Information

Employee Name: _____ Social Security Number: _____
Last First MI

Home Address: _____
Street City State Zip Code

Date of Birth: _____ Date of Hire: _____ Gender: _____ Marital Status: _____

Payroll Frequency: ☐ Weekly (52) ☐ Bi-weekly (24) ☒ Semi-monthly (24) ☐ Monthly (12) ☐ Other _____

Effective Date: 10/1/2020 Date of First Payroll Deduction: 10/15/2020

Benefit Election or Waiver

Pre-Tax Salary Reductions: (Employee contributions to the Employer-Sponsored Benefit Plans) AMOUNTS ARE PER PAY PERIOD

Flexible Spending Account Elections:

☐ FSA Medical Account: Annual Election: $_____ Per Pay Check Deduction: $_____

☐ FSA Dependent Care Account: Annual Election: $_____ Per Pay Check Deduction: $_____
(Cannot exceed $5,000 per family annually)

☐ I waive my right to participate in the FSA Medical and the FSA Dependent Care Accounts at this time.

☐ I do not want my FSA Account information accessible from the secure website.

Please note, the amounts you enter above under Pre-Tax Salary Reductions and/or Flexible Spending Account Elections may be increased or decreased during the Plan Year to correspond with increases or decreases to the required amount of employee contributions set by your employer and/or the IRS.

Authorization Information

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown under Pre-Tax Salary Reductions and Flexible Spending Account Elections headings shown above. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date listed above. I further authorize future adjustments in the amount of the salary reduction in the event the cost of coverage in any program selected above under the heading Pre-Tax Salary Reductions is changed by the carrier during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan.

I have read the Summary Plan Description with the Plan Information Summary given to me by my employer.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in the family status as listed in the Summary Plan Description.

Prior to the beginning of the plan year each year, I will be offered the opportunity to change my benefit election for the following plan year. If I do not return an enrollment for at that time, I will be treated as having elected to continue my benefit coverage/salary reduction "as is" for the upcoming year.

I understand that any remaining balance in my Flexible Spending Account at the end of the plan year will be forfeited in accordance with the IRS Regulations.

Employee Signature: _____ **Date:** _____

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VISION · STRATEGY · BALANCE

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Authorization for Direct Deposit for FSA and/or HRA Reimbursements

Complete the section below to have your FSA and/or HRA reimbursements directly deposited into your checking or savings account. If you are not participating in the FSAs or your employer does not offer an HRA plan, then this section does not apply.

Bank Name: _____ Account Type: ☐ Checking ☐ Savings

Bank Routing Number: _____ Bank Account Number: _____

I authorize my FSA and/or HRA reimbursement to be sent to the financial institution named above to be deposited in the designated account. In the event that funds are deposited erroneously into my account, I authorize my FSA and/or HRA provider to debit my account not to exceed the original amount. I also understand that it is my responsibility to update my FSA and/or HRA provider if my account information changes and that I will be charged a $20 fee for returned direct deposits for a closed account, incorrect account or routing number as well as any block on my account that will prevent my FSA and/or HRA provider from completing the transaction. I understand that all direct deposits are made through the automated clearing house (ACH), and that availability is subject to the terms and limitations of the ACH as well as my financial institution.

Employee Signature: _____ **Date:** _____

Please provide a voided check for the account listed above. Do not use a deposit slip as the account information could be incorrect.

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