



Missouri State Employees' Cafeteria Plan  
Election Agreement  
Plan Year 2012

**MOCafe**

I wish to have my salary redirected from the first day of \_\_\_\_\_ through December 31, 2012 in each of the categories below. This agreement is subject to the terms of the Missouri State Employees' Cafeteria Plan, Flexible Medical Benefits Plan, and/or Dependent Care Assistance Plan, and revokes any prior election under these plans. **My cost for qualified insurance plans listed in Section A will automatically be deducted pre-tax unless I select "Cancel Pre-Tax" for a particular Section A category.**

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Name \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Last, First MI) Social Security Number

Street \_\_\_\_\_

City \_\_\_\_\_ Agency/Org or University  
State, Zip \_\_\_\_\_

Email address \_\_\_\_\_

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**Section A: Premium Only Participation: POP** (See instructions on page 19 of the Enrollment Guide).

If you select to cancel pre-tax insurance premiums, it will not cancel your coverage. It will, however, mean that you will pay Federal and State Income taxes, and FICA taxes on all insurance premiums. **If you leave these boxes blank, all of your qualified insurance premiums will automatically be deducted pre-tax, saving you 25% or more on these expenses.** Please note that there is a \$.16 per month administrative fee if you do not cancel the POP.

|                               |                               |                               |                               |   |
|-------------------------------|-------------------------------|-------------------------------|-------------------------------|---|
|                               | <b><u>Cancel Pre-Tax*</u></b> |                               | <b><u>Cancel Pre-Tax*</u></b> | <b><i>*Selecting "Cancel" does not cancel your insurance coverage or payment.</i></b> |
| Health (State-sponsored only) | <input type="checkbox"/>      | Vision (State-sponsored only) | <input type="checkbox"/>      |   |
| Dental (State-sponsored only) | <input type="checkbox"/>      | Qualifying Voluntary Products | <input type="checkbox"/>      |   |

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**Section B: Flexible Spending Accounts: FSA** (See instructions on page 19 of the Enrollment Guide).

(Elections for both categories in this section will terminate at the end of each year unless you re-elect for the following year)

| <i>Do not put insurance deductions in this Section B!</i> | <u>Deduct from each paycheck</u> | <u># of paychecks in 2012</u> | <u>Annual Amt. (\$5,000 or less)</u> |
|---|----------------------------------|-------------------------------|--------------------------------------|
| Flexible Medical FSA<br>(excluding insurance premiums)    | _____ . _____                    | _____                         | ____, ____ . ____                    |
| Dependent Care FSA<br>(Adult/child care)                  | _____ . _____                    | _____                         | ____, ____ . ____                    |

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**DIRECT DEPOSIT:** I authorize Central Bank to credit my account number \_\_\_\_\_ with (name of bank) \_\_\_\_\_, routing number \_\_\_\_\_ with my Health Care FSA and/or my Dependent Care FSA payments. This account is a \_\_\_\_\_ (checking, savings, money market) account. Please attach a copy of a void check. My administration fee will be \$2.96 per month for Section A & B combined.

Send a notice of payment with each direct deposit to the email address listed above.  Do not send payment notices to me.

**CHECK:** I wish to have a check mailed to me for my Health Care FSA and/or my Dependent Care FSA payments instead of direct deposit. My administration fee will be \$3.46 per month for Section A & B combined.

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I have received the **MOCafe** Plan and Enrollment Guide and understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Plan and Enrollment Guide.

Employee's signature: \_\_\_\_\_ Date \_\_\_\_\_