Flexible Spending Account (FSA)

2100 Covington Centre, Suite B,
Covington, LA 70433

Benefit Election Form

985.242.7055HCHealthBenefits.com

~~Group Name~~: GUARANTY CORP.
Group Number: 92478
Plan Year: 10/1/24 - 9/30/25

PERSONAL INFORMATION

Last Name	First Name(or initial)	Middle Name (or initial)	Social Security Number

Home Address	City	State/Zip	Home Phone	Email Address

Sex	Martial Status	Date of Birth	Date of Hire
☐ Male ☐ Female	☐ Single ☐ Married		

BENEFIT ELECTION:

#payroll deduction: $

1. **Health Care Flexible Spending Account Election Maximum:** **Enter Total Election Amount Annual**
   #payroll deduction: 24 $ _____ **Enter Pay Period Amount**
   1. $
   2. $
2. **Dependent Care Flexible Spending Account Annual Election Maximum:** **Enter Total Election Amount**

$

TOTAL PER PAY PERIOD(1+2) _____

Effective Date: 10/1/2024 Begin Deductions with Check Date of: 10/15/2024

If you are enrolling in the Flexible Spending Account, Please Check the box stating, "I wish to participate in the Flexible Spending Account Benefits Plan."
If you are not enrolling in any of the benefits above, please mark the box stating, "I do not wish to participate in the Flexible Spending Accounts Benefits Plans."

☒ **I wish to participate in the Flexible Spending Account Benefits plan.** I have read and agree to the terms set forth on the back of his form.

☐ **I do not wish to participate in the Flexible Spending Account Benefits.** This waiver will acknowledge that I have been informed of the terms of the above-reference plan. I elect to waive all pre-tax benefits under the Flexible Spending Account Benefits Plan. Except for a change in status, I understanc that I cannot elect pre-tax benefits until the next Open Enrollment.

Signature	Social Security Number	Date
		9/26/2024

HealthComp

Terms and Conditions

I understand that:

If my required contributions for the elected insurance benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

Reimbursement under the spending accounts will be available only for "qualifying health care expenses" and "qualifying dependent care expenses" as described in the Summary Plan Description. I agree to notify my Employer if I have any reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state, local income tax, or Social Security tax for any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.

This agreement will automatically terminate if the Plan is terminated or discontinued, if I cease to receive compensation from the Employer which, before redirection, is at least equal to the amount of that redirection.

Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit coverage and amount of compensation redirection for insurance benefits then in effect for the new plan year.

It will be necessary for me to complete and return a new election form if it is my desire to participate in the unreimbursed medical and/or dependent care portion(s) for the new plan year.

I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election). However, I am not eligible to add, change, or revoke my Health Care deduction at any time during the year, even in the event of a change in family status.

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

The redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements of benefit plans.

The amount of my compensation redirection will be credited to an insurance, medical care reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed, up to the balance in that account, for the applicable expenses incurred during the year.

Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year.

My future Social Security benefits may be slightly reduced as a result of my election.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN 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 REDIRECTION AGREEMENT RELATING TO SUCH PLAN.