Benefit Election Form 2025

FSA, Insurance, and Waiver of Coverage

This form provides an opportunity to participate in ARC's benefit programs for healthcare reimbursement and insurance coverage for the upcoming year. You can also use this form to modify an existing plan or waive[1] coverage altogether. Please complete the sections below.

Flexible Spending Arrangement (FSA)

An FSA helps you pay certain health and dependent care costs with tax-free dollars. This plan provides a means to discretely reimburse qualified expenses and may reduce your annual income tax burden. The IRS adjusts FSA rules periodically, so see ARC Human Resources for current details.

Redirecting some of your wages into an FSA will reduce your annual taxable compensation by the total specified below. Note that reducing your taxable income may potentially lower your Social Security benefits.

This arrangement will remain in effect for the next calendar year, though life-changing events may qualify as grounds for modification. Examples include termination of employment; change to part-time status by you or your spouse; marriage; divorce; death of an immediate family member; birth or adoption of a child; significant change in premiums or benefits of the health coverage maintained by you or employer, or your spouse.

☐	**Yes**, I accept these terms and elect to participate in ARC's FSA as indicated below:		
	Unreimbursed Health Care Expenses:	$_____ per paycheck	*Limit: $100 per paycheck, or $2,400 for the year*
	Dependent Care Expenses:	$_____ per paycheck	*Limit: $208.33 per paycheck, or $5,000 for the year*
☐	**No**, I elect not to participate in ARC's flexible spending program at this time.		*See footnote below about waiver of participation[1]*

Insurance Deduction

ARC offers some forms of insurance coverage as an employee benefit, which the company pays on your behalf. Examples include medical, dental, vision, life, and disability coverage. Participating in ARC's insurance plans may reduce your taxable income.

☐	**Yes**, I accept these terms and authorize ARC to reduce my wages each pay period by the amount necessary to help pay for this coverage.	
☐	**No**, I will not participate in ARC's offer of health-related insurance coverage.	*See footnote below about waiver of participation[1]*

Authorization

Effective Date:		(*Usually the start of the next calendar year)*	
Printed Name:		**Last 4 Digits of SSN:**	
Signature:		**Today's Date:**	

[1] **Waiver of Participation:** I acknowledge that ARC has provided the opportunity to participate in the above listed benefit plans. However, I choose not to participate in one or more of them at this time. By waiving participation, I realize that I will not again become eligible until the next plan anniversary date, or if earlier, occurrence of a life-changing event.