



# Dedicated Transport Holdings, LLC

## Flexible Spending Account Plan Election Form

ACCOUNT HOLDER INFORMATION:			
SSN:	Name:	Date of Birth:	
Street Address:	City:	State:	Zip Code:
Daytime Phone:	Email:	Plan Year:	
First Payroll Deduction Date:	Benefit Effective Date:	<b>January 1, 2012</b>	
Payroll Schedule (i.e. Weekly, Bi-Weekly, Bi-Monthly, etc.):			

**Regarding my salary redirection agreement and my election of benefits, I understand that:**

In accordance with my rights under the plan, I elect the following benefits and designate the following amount for the plan year specified above. The Employer and I agree that my cash compensation will be reduced by the amount set forth below for each pay period and plan year (or during such portion of the year as remains after the date of this agreement).

ANNUAL ELECTION:
<input type="checkbox"/> No, I elect not to participate in the Employer sponsored Flexible Spending Account Plan.
<input type="checkbox"/> Yes, I elect to participate in the Employer sponsored Flexible Spending Account Plan and have contributions payroll deducted on a pretax basis.

	Amount Per Pay	Annual Amount
<b>Medical Care Reimbursement Account</b> <i>( min \$234.00 / max \$3,500.00 )</i>	\$	\$
<b>Dependent Care Reimbursement Account</b> <i>(maximum of \$5,000)</i>	\$	\$

AUTHORIZATION TO RELEASE ACCOUNT INFORMATION:		
<input type="checkbox"/> No <input type="checkbox"/> Yes (Complete the section below)		
By signing and dating this document, I am authorizing Plan Services to discuss and/or release information regarding my flexible spending account to:		
Name:	Relationship:	SSN:
<ul style="list-style-type: none"> <li>• This authorization allows Plan Services to discuss or release the requested information directly to the person stated above, and to no other parties.</li> <li>• This authorization applies to any flexible spending and/or dependent care reimbursement plans I may have with your company.</li> <li>• This authorization is valid until notified otherwise, and can be revoked by the member of the plan at anytime.</li> </ul>		
<b>Employee's signature:</b>		<b>Date:</b>

**Regarding my salary redirection agreement and my election of benefits, I understand that:**

1. I may not change elections during the Plan Year unless there is a qualified change in my family status. A change in group health (medical, dental or vision) plan coverage does not qualify as a change in family status.
2. The administrator is authorized to adjust the amount of my salary redirection and benefit if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
3. My right to any benefits hereunder is subject to all terms and conditions of the Plan and the terms and conditions of any other Plan through which a particular benefit is provided.
4. Any Flex balances that are not used by your Plan's claim filing deadline will be forfeited and may not be paid to me in cash or used to provide benefits in a later year.
5. By electing coverage under an Employer sponsored group health plan, I will automatically have my premium contribution payroll deducted on a pretax basis under the Plan.
6. I understand that our Service Plan Description and other plan documents are available online at [www.vfgps.com](http://www.vfgps.com).

**Employee's Signature:** \_\_\_\_\_

# Direct Deposit Authorization

Employee Name \_\_\_\_\_ Employee SSN \_\_\_\_\_

Employer **Dedicated Transport Holdings, LLC**

I hereby authorize **Vantage Financial Group Plan Services, Inc.** (Claims Administrator) to initiate credit and debit entries to my checking or saving account indicated below and the depository named below (Depository) to credit/debit the same to such account. **(check one):**

**Checking Account**

**Savings Account**

**Please see sample check below for help in identifying account and transit routing numbers:**

Account Number \_\_\_\_\_

Depository (Financial Institution) \_\_\_\_\_ Branch \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Bank ACH Transit Routing Number \_\_\_\_\_

This authority will remain in full force and effect until the Claims Administrator has received written notification from me of its termination in such time and in such manner as to afford the Claims Administrator a reasonable opportunity to act on it.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mail to:** Vantage Financial Group Plan Services 6200 Rockside Road, Suite 100 Cleveland, OH 44131-8082 Attn. Flex Dept.

**Online:** [www.vfgps.com](http://www.vfgps.com) (see your Plan Highlight sheet for more information)

**Fax:** (216) 642-4863

**Secure Email:** [www.vfgps.com](http://www.vfgps.com) (Do not use [csflex@vanfin.com](mailto:csflex@vanfin.com).)

**\*\*An actual *voided check* must be attached\*\***  
**Tape or staple voided check here**

Please do not attach a deposit slip. If an actual check is not available to attach (i.e. some savings accounts) you are responsible for obtaining the correct ACH transit routing number from your financial institution.

**\*\* SAMPLE CHECK\*\***

<b>Sample Company</b> 6200 Rockside Road Cleveland, OH 44131	ABC Bank Main Office Cleveland, OH 44131	410	<u>6-101</u>	<b>90381</b>
<b>Pay</b> One Dollar and 00/100 cents	<b>Date</b> 04/01/01	<b>Amount</b> <b>\$1.00</b>		
<b>TO THE ORDER OF</b> Joseph Smith 1234 Main Street Cleveland, OH 44131	<b>ID: 000-00-0000</b>			
"" 90381""	':041001013':	70121395""		
*[ Check #]	[ Routing Transit # ]	[ Account # ]		
*(Check # may be to right or left)				