

Employee Information

Last 4 of SSN: Date of Birth:

Employer Name: Dept/Location:
(Optional)

First Name: Middle Initial: Last Name:

Employee Home Address:

City: State: Zip:

Home Phone #: E-Mail:
Help us go green! If provided, we will use your email as our primary method of contact.

Employment Date: Plan Effective Date: Male Female

Employer Information

(Employer to complete the information below.)

Date of 1st Payroll Deduction: 12 Month Plan Year

Employee Plan Effective Date: Short Plan Year

Employee Elections

(Employee to complete the information below)

A. Group Medical Premiums *(If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a pre-tax basis unless you notify your Human Resource or Personnel Department.)*

	Annual Election	# of Payroll Deductions	\$ Per Pay Check
B. Health FSA	<input type="text"/>	/ <input type="text"/>	= <input type="text"/>
Employer Contribution	<input type="text"/>	/ <input type="text"/>	= <input type="text"/>
C. Dependent Care	<input type="text"/>	/ <input type="text"/>	= <input type="text"/>
Employer Contribution	<input type="text"/>	/ <input type="text"/>	= <input type="text"/>
D. Limited FSA	<input type="text"/>	/ <input type="text"/>	= <input type="text"/>
Employer Contribution	<input type="text"/>	/ <input type="text"/>	= <input type="text"/>
E. Administration Fee (if any)	<input type="text"/>	/ <input type="text"/>	= <input type="text"/>
TOTALS	<input type="text"/>		<input type="text"/>

No, I do not want to enroll. If a change in status occurs, I may have the right to enroll in the plan at that time (if my employer's plan allows).

Yes, I want to enroll. The IRS regulations state four conditions: 1) Any expenses you incur must be within the plan year; 2) Any expenses you incur must not be covered by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes. Please see the Summary Plan Description for details.

Signature: Date: