

# ENROLLMENT FORM

**PLEASE COMPLETE ENTIRE FORM**

Employer			Plan Effective Date Month Day Year			Plan Year End Date Month Day Year			1st Deduction Month Day Year		
Employee's First Middle Initial Last Name			Social Security #			Hire Date Month Day Year					
Employee's Home Address Street City State Zip Code			E-Mail Address								
Union Member Y N	Date of Birth Month Day Year		Deduction Frequency ___12 ___24 ___26 ___52 ___Other				Pay Periods Remaining in Plan Year		<input type="checkbox"/> New Enroll <input type="checkbox"/> Re-Enroll		

Please refer to your Summary Plan Description to determine which options are available in your plan.

**I authorize my Employer to deduct the following amounts from my compensation on a pre-tax basis:**

Flexible Spending Accounts (FSA)	Pay Period Deductions	Plan Year Annual Elections	For Office Use Only
General-Purpose Medical FSA	\$ _____	\$ _____	_____
Limited-Purpose Medical FSA	\$ _____	\$ _____	_____
Post-Deductible Medical FSA	\$ _____	\$ _____	_____
Dependent Care FSA	\$ _____	\$ _____	_____
Individual Premium FSA	\$ _____	\$ _____	_____
<b>Health Savings Account (HSA)</b>	\$ _____	\$ _____	_____
<b>Premiums</b> (To the extent available through your employer's plan.)			
Health Premium	\$ _____	\$ _____	_____
Dental Premium	\$ _____	\$ _____	_____
Term Life Premium	\$ _____	\$ _____	_____
Disability Premium	\$ _____	\$ _____	_____
Other Pre-Tax Premium	\$ _____	\$ _____	_____
Other Pre-Tax Premium	\$ _____	\$ _____	_____
<b>Administration Fee</b>	\$ _____	\$ _____	_____

**I authorize my Employer to deduct the following amounts from my compensation on an after-tax basis:**

Other After-Tax Premium:	\$ _____	\$ _____	_____
Other After-Tax Premium:	\$ _____	\$ _____	_____

**CERTIFICATION AND ACKNOWLEDGEMENT:** I certify to my best knowledge that: (i) the above information is correct; and (ii) the individuals for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I acknowledge that: (i) my Flexible Benefit Plan elections, except my HSA election, are effective for the plan year and cannot be changed unless a qualified change of status is experienced by me, my spouse, or one of my eligible dependents; (ii) I cannot participate in a general-purpose medical reimbursement plan or have "other coverage" while I am making HSA contributions; (iii) I will forfeit any amounts remaining in my Flexible Benefit Plan accounts not used for eligible expenses during the plan year; and (iv) my Social Security benefits may be reduced because the tax-free benefits under the Plan reduce the amount of contributions made on my account to the Federal Social Security system. I AM AWARE THAT ANY ELECTIONS MADE FOR THE PLAN YEAR ARE IRREVOCABLE AND WILL REMAIN IN EFFECT UNLESS OTHERWISE PROVIDED IN THE PLAN.

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

**DECLINATION OF PARTICIPATION:** I have been given the opportunity to participate in the above plan and have elected not to do so.

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