

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	\$ _____	\$ _____	_____
Health Savings Account (HSA)	\$ _____	\$ _____	_____
Premiums (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	\$ _____	\$ _____	_____
Administration Fee	\$ _____	\$ _____	_____

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 _____