

# ENROLLMENT FORM

PLEASE COMPLETE ENTIRE FORM

Employer			Plan Effective Date Month   Day   Year			Plan Year End Date Month   Day   Year			1 <sup>st</sup> 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 (optional)				
Gender (Circle one) M or F	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 <input type="checkbox"/> Union <input type="checkbox"/> Non-Union			

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** (if applicable) \$ \_\_\_\_\_ \$ \_\_\_\_\_ \_\_\_\_\_

I AUTHORIZE MY Employer to deduct the following amounts from my compensation on an **after-tax** basis.

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

**CERTIFICATION AND ACKNOWLEDGEMENT:** I certify to my best knowledge that: (1) the above information is correct; and (2) the individuals for whom I will be claiming dependent or childcare expense either reside with me in a parent-child relationship or are eligible dependents as defined in the Plan document. I acknowledge that (i) I cannot participate in a general-purpose medical reimbursement plan or have "other coverage" while I am making HSA contributions; (ii) I will forfeit any amounts remaining in my Flexible Benefit Plan accounts not used for eligible expense during the plan year; and (iii) 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 \_\_\_\_\_