

BENEFITS DESIGN GROUP, INC.

P.O. BOX 370 Onalaska, WI 54650 1-800-342-8235 or (608) 781-2159

ENROLLMENT FORM

PLEASE COMPLETE ENTIRE FORM

Employer			Plan Effective Date Month Day Year			Plan Year End Date Month Day Year			1 st 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 or 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. I authorize Benefits Design Group to disclose information with my employer for Plan operational purposes; or check here to opt out of authorization.

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 _____