



SECTION 125  
EMPLOYEE ENROLLMENT FORM

**\*\* NOTE\*\***

**Online enrollment with electronic signature is available. Call 800-871-9011 for details.**

**Please Print**

Company Name: \_\_\_\_\_ Plan Year: 2011

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Init.: \_\_\_\_\_

Address : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Hire \_\_\_\_\_ Date of Birth \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

Expenses for reimbursement must be incurred **during** the plan year

With regard to my pay reductions under this agreement, I understand that:

- Expenses for reimbursement must be incurred during the plan year.
- If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my reduction will automatically be adjusted.
- I cannot change or revoke this pay reduction agreement at any time during the year unless I have a change in status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, HIPPA qualifying changes, termination or commencement of employment of my spouse's employment status.
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections. If I do not complete and return a new election form at that time, I will be treated as having elected to continue only my insured benefits then in effect for the new plan year.
- Dependent care reimbursement will be available only for qualifying dependent care expenses as described in the Internal Code Section 129, and I understand I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this program. I further acknowledge that the total election for me and my spouse cannot exceed the amount outlined in the employer plan document.

**Elections**

**Check All That Apply**

**Annual Elections**

**Pay Period Election**

- |                          |                               |          |                       |          |
|--------------------------|-------------------------------|----------|-----------------------|----------|
| <input type="checkbox"/> | Group Health Insurance        | \$ _____ | ÷ _____ pay periods = | \$ _____ |
| <input type="checkbox"/> | Dependent Care Account        | \$ _____ | ÷ _____ pay periods = | \$ _____ |
| <input type="checkbox"/> | Unreimbursed Medical Expenses | \$ _____ | ÷ _____ pay periods = | \$ _____ |
| <input type="checkbox"/> | Individual Health Insurance   | \$ _____ | ÷ _____ pay periods = | \$ _____ |
| <input type="checkbox"/> | Other : _____                 | \$ _____ | ÷ _____ pay periods = | \$ _____ |

I acknowledge I have been informed of the terms of the flexible spending account options. Even though I am eligible to participate in the plan, I hereby elect not to enroll. This waiver will remain in effect for the remainder of this plan year; however, I may enroll this plan year if I have a change in status.

**ELECTIONS MADE AT THE BEGINNING OF THE PLAN YEAR CANNOT BE CHANGED UNLESS YOU HAVE A CHANGE IN FAMILY STATUS.**

I understand that by signing and submitting this form, I am making an irrevocable election for the Plan year indicated above.

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_