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: _______________

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

- 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
☐ Group Health Insurance	$______________	÷____ pay periods	=	$______________
☐ Dependent Care Account	$______________	÷ ____pay periods	=	$______________
☐ Unreimbursed Medical Expenses	$______________	÷ ____pay periods	=	$______________
☐ Individual Health Insurance	$______________	÷ ____pay periods	=	$______________
☐ 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: _________________________