Employee Flexible Benefits Enrollment Form

☐ New Plan Year Coverage
☐ New Employee Coverage

Employee Information

Effective Date / /	Employer

Name	Social Security Number - -

Address	Date of Hire / /

City	State	Zip	Date of Birth / /	☐ Male ☐ Female

Telephone Number ( ) -	Pay Cycle ☐Weekly ☐Biweekly ☐Semi-monthly ☐Monthly

Dependent Information

Name	Relationship	Birthdate	Sex	Social Security #	Fulltime Student?
			M / F	- -	☐ Yes ☐ No
			M / F	- -	☐ Yes ☐ No
			M / F	- -	☐ Yes ☐ No
			M / F	- -	☐ Yes ☐ No
			M / F	- -	☐ Yes ☐ No

Benefit Selections

☐ Non Employer Provided Insurance Premiums	$__________ **Annual Election** ÷ _____ # of payrolls left = $__________ Per pay period
☐ Healthcare Reimbursement Account The maximum you may elect is $	$__________ **Annual Election** ÷ _____ # of payrolls left = $__________ Per pay period
☐ Dependent Care Reimbursement Account The maximum you may elect is $5,000.00 or $2,500.00 if married and filing separately	$__________ **Annual Election** ÷ _____ # of payrolls left = $__________ Per pay period

I have read and understand the Summary Plan Description I have received regarding my options under the Flexible Benefit Plan. I hereby apply for the benefit options listed above. I authorize my employer to reduce my cash compensation by the amounts set forth above.

I recognize that I must submit a claim form and documentation of qualified expenses to receive reimbursement from my Flexible Benefits Plan. I understand that any unused funds at the end of the Plan Year will be forfeited.

I understand that the benefit options elected above will remain in force throughout the duration of the plan year, and cannot be revoked or modified unless I have a qualifying change in family status or terminate employment with the Plan Sponsor.

Employee Signature: ____ **Date:** ____________________

Waiver of Pre-tax Benefits

I elect to waive all pre-tax benefits under the Flexible Benefits Plan, but I understand that I may elect similar coverage(s) on an after-tax basis. I understand that the benefit options elected above will remain in force throughout the duration of the plan year, and cannot be revoked or modified unless I have a qualifying change in family status or terminate employment with the Plan Sponsor.

Employee Signature: ____ **Date:** ____________________

Please direct any questions or comments regarding your Flexible Benefits Plan to:

Pension Plan Services, Inc.
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