FLEXIBLE BENEFIT ENROLLMENT FORM

Company Name _____ **Plan Year** _____

Payroll Frequency: ◯ Weekly (52) ◯ Bi-Weekly (26) ◯ Semi-Monthly (24) ◯ Monthly (12)

Date of First Deduction: _____ Number of Deductions in the Plan Year: _____

Employee Information

First Name	Last Name	Social Security #	Employee ID #

Address	City	State	Zip Code	Day Time Phone Number

Email Address

Date of Hire: _____ Effective Date: _____ Date of Birth: _____

Benefit Elections

Enter the per paycheck amount of your allocation(s) for the Plan Year to the account(s) of your choice and multiply by the number of paychecks you receive during the Plan Year to arrive at your annual contribution.

	Per Paycheck Reductions		Number Of Paychecks		Annual Contribution
A. Pre-Tax Insurance Premiums (Contributions to the Employer-Sponsored Benefit Plans*)	$ _____	x	_____	=	_____
B. Health Care Flexible Spending Account (Cannot exceed your Plan's maximum.)	$ _____	x	_____	=	_____
C. Dependent Care Flexible Spending Account**	$ _____	x	_____	=	_____
Total Authorized Pre-Tax Salary Reductions***	$ _____				_____

**Please complete the green "Mandatory Statement for Dependent Care" form. You can obtain the form from your human resources department or from the Flex Administrators web site at www.flexadministrators.com

*This amount may be adjusted during the Plan Year to allow for changes in contributions required by your employee benefit plan.
***If your employment is temporarily interrupted and you don't receive pay, you will still be required to pay your full annual contribution and make other arrangements with your Employer to do so.

Payroll Deduction Authorization

I understand that the reduction(s) specified above will be in effect for such Plan Year and can be revoked or changed only if the election change is due and consistent with a change in my status as defined in Section 125 of the Internal Revenue Code. I further understand that any salary reduction amounts not used for eligible expenses incurred by the end of the above plan year (or by the end of any subsequent grace period provided by the Plan) will be forfeited in accordance with Plan provisions. If my employment ceases, my participation in the Plan will cease. Except as otherwise provided by COBRA no further contributions will be made to the Plan on my behalf, although I may be entitled to reimbursements for claims incurred prior to my date of termination.

I hereby authorize my employer to reduce my salary on a pre-tax basis by the amount of my benefit election(s) specified above.

Employee signature _____ Date _____

Authorization to Use/Disclose Health Information

I authorize the use or disclosure of my individually identifiable health information by or to my spouse, any health care provider, any insurer or claims administrator, or any other entity providing services in connection with the Plan in order to process my enrollment in the Plan or to process any claim for my Plan benefits. This authorization is effective until the date I terminate participation. Further, I have read and I understand the following: (1) I may revoke this authorization at any time before its expiration date by notifying Employer in writing, but the revocation will not have any effect on any actions the Plan took before it received the revocation; (2) I may see and copy the information described in this authorization if I ask for it; (3) I am not required to sign this authorization to receive my health care benefits (enrollment, treatment, or payment); and (4) The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Employee signature _____ Date _____ Spouse signature _____ Date _____

(Rev. 11/06)