



PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: _____

Participant First Name: _____ Last Name: _____

Social Security #: [] [] [] - [] [] - [] [] [] [] Date of Birth: _____ / _____ / _____

Address: _____

City, State, Zip: _____ Phone Number: _____

E-mail Address: _____ (Notification of direct deposit payments are only sent via e-mail)

Pay Period: Weekly Semi-Monthly (twice a month) Bi-Weekly (every other week) Monthly

PREMIUM CONTRIBUTIONS

- I elect to participate (check all that apply)
- Health Insurance Group Life Insurance Disability Insurance Dental Insurance
- Health Savings Account (HSA) Contributions Other(s) _____

The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.

I elect NOT to participate

EMPLOYER USE

Please complete for mid-year enrollments

Date of first deduction: _____

Eligibility date: _____

MEDICAL REIMBURSEMENT ACCOUNT

- I elect to participate (not to exceed employer limit of \$ _____)
- \$ _____ per pay x _____ (# of pays in plan year) = \$ _____ Annually (do not round)
- Is this Medical Reimbursement Account a Limited Purpose Account (see page 6)*
- I elect NOT to participate

DEPENDENT CARE ACCOUNT

- I elect to participate (not to exceed \$5000 or \$2500 if married filing separately)
- \$ _____ per pay x _____ (# of pays in plan year) = \$ _____ Annually (do not round)
- I elect NOT to participate

DIRECT DEPOSIT (not all employers allow direct deposit as a reimbursement option)

- I elect to participate (there is no need to complete this section, unless you are changing accounts)
- checking account OR savings account

CHECK EXAMPLE

⑆ 123456789 ⑆0000123456 ⑆1234

routing number account number check number

If you would prefer, you can attach a voided check.

Financial Institution (name of bank): _____

Routing Number (always 9 digits): [] [] [] [] [] [] [] [] [] Account Number: _____

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

TEAR ALONG THIS LINE