



Flexible Benefits Plan Participation Form

Company Name: _____ Employee Name: _____

Home Address: _____ Social Security: _____

_____ Birth Date: _____

_____ Hire Date: _____

Premium Only Plan – Insurance Premiums:

Your portion of the cost for employer-sponsored insurance plans elected for yourself and dependents is automatically pre-taxed under the Premium Only Plan. If insurance premiums are available to you please list them. Completing the amount information is optional.

Dental Insurance Premium: \$ _____ Per Pay Period

Health Insurance Premium: \$ _____ Per Pay Period

Vision Insurance Premium: \$ _____ Per Pay Period

CHECK HERE IF YOU WISH TO HAVE YOUR INSURANCE PREMIUMS AS AFTER-TAX DEDUCTIONS.

Flexible Spending Account:

REQUEST TO PARTICIPATE

***** Effective January 1, 2011, in order for participants to receive reimbursement for over-the-counter medications, they will need to be prescribed by a physician. Please choose election carefully. *****

A. FSA-Medical/Dental/Vision Expenses

The cost paid by you or your dependents for annual deductibles, co-pays, eye care, dental care, prescriptions, etc, which is not reimbursed by insurance.

Annual Election
\$

Amount you will contribute per pay period
\$

B. FSA-Dependent Care

Employment related care for qualifying dependents (Children under age 13 or physically disabled adult)

Annual Election
\$

Amount you will contribute per pay period
\$

Acknowledgement: My employer’s benefits have been explained to me and I understand that:

1. I cannot change or revoke my election unless I have a change in family status as defined by the FLEXPLAN, usually marriage, divorce, death of a spouse or child, birth or adoption of a child or termination of a spouse’s employment
2. My employer may adjust premiums if provider rates change, but I may not be able to change my election during the PLAN YEAR.
3. The total amount deducted for the Flexible Spending Account must be used during the PLAN YEAR or forfeited under IRS rules.
4. Participation in this Plan may mean I will pay less Social Security tax, which could slightly reduce my Social Security Benefits.
5. I can only submit claims for expenses incurred while I was an ACTIVE participant in the Plan.

Direct Deposit Option: If you wish to utilize Direct Deposit, you will need to include a copy of a voided check along with this form. **Choose one of the following:** Checking Savings Account info already on file

By signing below, I authorize my employer to adjust my compensation by the amount of my benefit elections above.

Request to Waive – The Cafeteria Plan has been explained to me and I elect to waive participation. **I understand my next opportunity to enter the Plan will be the next open enrollment period.**

Employee Signature: _____

Date: _____