

Flexible Benefits Plan  
**Enrollment Form**

New Enrollment     Renewal

Plan Year: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Pays/Year:  52  26  24  12

Employee Name: \_\_\_\_\_

SS #: \_\_\_\_\_

Street Address 1: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Street Address 2: \_\_\_\_\_

Home Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

1<sup>st</sup> Payroll Date: \_\_\_\_\_

Dependents:	<u>Name</u>	<u>Relationship</u>	<u>SS#</u>	<u>DOB</u>	<u>Disabled</u>
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Compensation Status:     Under \$25,000     Over \$100,000     1% Owner earning over \$150,000  
 \$25,000 - \$100,000     5% Owner     Officer earning over \$140,000

Reimbursement Method:     Check     Debit Card [if permitted]  
 Direct Deposit [please complete Direct Deposit Authorization Form]

Benefits:	<u>Annual Expense</u>	<u>Employer Contribution</u>	<u>My Annual Contribution</u>	<u>My Per Pay Contribution</u>
<u>Premium Conversion</u>				
<input type="checkbox"/> Health Insurance	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Dental Insurance	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Vision Insurance	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Group Term Life Insurance	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> _____	\$ _____	\$ _____	\$ _____	\$ _____

Health Care FSA - [if available under the plan] -The annual amount may not exceed \$ \_\_\_\_\_:  
\$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_

Dependent Care FSA - [if available under the plan] -The annual amount generally may not exceed \$5000:  
\$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_

Adoption Assistance FSA - [if available under the plan] -The annual amount generally may not exceed \$10,960:  
\$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_                      \$ \_\_\_\_\_

Health Savings Account - [if available under the plan] - The annual amount may not exceed the lesser of your deductible or \$ 2,700 (Single Coverage) or \$ 5,450 (Family Coverage).

Ex: \$ 1,000 deductible / 12 = \$ 83.33 x 11 = \$ 916.63 for 2005  
Paid bi-weekly, assuming 2 pays per month; \$ 83.33 / 2 = \$41.67 per pay

<input type="checkbox"/> Single Coverage	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Family Coverage	\$ _____	\$ _____	\$ _____	\$ _____

I hereby certify that: I have read the Terms and Conditions of Participation; the information above is true to the best of my knowledge and belief; and, the individuals on whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for support. I hereby agree to reduce my compensation by the amount of contribution required for the benefits I have elected above on a pre-tax basis, with such reduction continuing for each pay period until this Enrollment Form has been amended or revoked.

Date: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

Accepted and Agreed to on behalf of the Employer on \_\_\_\_\_ by \_\_\_\_\_.