

For changes please check one:
 Correction
 Change of personal information
 Change of family status
 Termination
EFFECTIVE DATE: _____

Company Name: _____
Flexible Spending Account & Premium Only Plan Enrollment Form
Plan Period: _____

Section I Employee Information

Social Security #	Name (Last, First, Middle Initial)	Home Phone
Date of Birth	Mailing Address	
City, State, Zip Code		Work Phone
email address		

Section II Pre-tax Premium Election

- Accept.** I elect to have my portion of the company's group insurance premiums (health, dental, vision, etc.) withheld from my paycheck before taxes.
- Waive.** I decline to have my portion of the company's group insurance premiums (health, dental, vision, etc.) withheld from my paycheck before taxes.

I have received and read the enrollment materials for these benefits. I understand that by signing this form I am electing to reduce my compensation in exchange for the coverages selected. I further understand that this election cannot be changed until a future benefits enrollment period or qualifying event occurs. I authorize payroll deductions for any required contributions for coverages elected.

Signature _____ Date _____

Section III Flexible Spending Account Elections

<i>Type of Account:</i>	<i>Pay period Amount:</i>	<i>Number of Pay Periods:</i>	<i>Total Annual Election:</i>
Health Care Spending Account	\$ _____	for _____ pay periods	\$ _____
Dependent Care Spending Account <i>Limits are: \$ 5,000.00</i>	\$ _____	for _____ pay periods	\$ _____

I have received and read the enrollment materials for these benefits. I understand that by signing this form I am electing to reduce my compensation in exchange for the coverage's selected. I further understand that this election cannot be changed until a future benefits enrollment period or a qualifying event occurs. I authorize payroll deductions for any required contributions for coverage's elected above.

Signature _____ Date _____