



Company Name: _____
 Division: _____
 Payroll Schedule _____

SECTION 125 ENROLLMENT FORM - ELECTION AND COMPENSATION REDUCTION AGREEMENT

Employee Name: _____ Social Security # _____

Home Address, City, State, Zip Code: _____

Date of birth: _____ Email Address (required if electing debit card): _____

Home phone #: _____ Mobile phone #: _____

CHECK ONE: New Enrollee _____ New Plan Year Enrollment _____ Amended Mid-Year Change _____

Reason for Mid-Year change: _____

EMPLOYEE ELECTION:

Beginning _____ I wish to have the following amounts deferred in each category under the Cafeteria Plan. Any previous election and compensation reduction is hereby revoked. These amounts will continue for each succeeding pay period until the agreement is amended or terminated. I understand that I cannot terminate insurance policies and change these amounts prior to the next plan year unless there is a change in family status, or in employment status, or other special circumstances. I understand that my Social Security benefits may be reduced.

AMOUNTS ARE PER PAY PERIOD

- Pre-Tax Premium:
 For **Group's** insurance coverage
 On separate benefit enrollment form(s), I have enrolled for certain insurance coverage and I have been provided with a schedule showing my share of the premiums for such coverage. _____ [Initials]
- Medical FSA for Health Savings Account Participants. Limited Scope Medical FSA per pay period: \$ _____
 If you **are enrolled** in a Health Savings Account plan, you must choose **limited scope** medical FSA for dental, vision, post deductible and over-the-counter medication expenses. IRS annual maximum is limited to \$2,850.00.
- Medical FSA for Non-Health Savings Account Participants. Full Scope Medical FSA per pay period: \$ _____
 If you **are not enrolled** in a Health Savings Account plan, you may choose a **full scope** medical FSA for all IRS section 125 eligible out-of-pocket medical expenses. IRS annual maximum is limited to \$2,850.00.
- Dependent Care Account \$ _____ per pay period
 IRS annual maximum is limited to \$5,000.00 for single parent and married filing joint tax return.
 IRS annual maximum is limited to \$2,500.00 for married filing separate tax return.

If you choose Health FSA and/or Dependent Care Account, please provide a list of your eligible dependents. All eligible dependents have to live in your household and be claimed as dependents under your tax return.

DEPENDENT'S NAME	RELATION TO PARTICIPANT	DATE OF BIRTH	DEBIT CARD
Employee Debit Card Election	SELF		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

YOUR APPROVAL

- I hereby request my employer to arrange for benefits which I have elected. I authorize my employer to make the proper deductions from my earnings as my contribution toward the cost of this Plan. I verify that all the information on this form is correct.
- If utilizing the FSA debit card, I agree to only use the card for eligible medical expenses, to not use the card for expenses already reimbursed, to not seek reimbursement under any other health plan for expenses paid with the card, and to acquire and provide documentation for expenses paid with the card upon request.

EMPLOYEE SIGNATURE: _____ DATE: _____

EMPLOYEE WAIVER

- _____ I elect not to participate in the Pre-Tax Premium Reduction.
 I understand that I may not enroll until the new plan year unless there is a change in family status.
- _____ I elect not to participate in Medical or Dependent Care FSA
 I understand that I may not enroll until the new plan year unless there is a change in family status.

EMPLOYEE SIGNATURE: _____ DATE: _____