Plan Enrollment Form

Employee Name: _____

T#: _____

Enrollment Type

__ Initial Request Participation
__ New Year Request
__ Waive

Benefit Account/Amount

__ HRA
__ FSA
__ Dependent Care FSA

HRA Enrollment Effective Date: _____
Semi-monthly (24) pay periods per year

Annual Company Contribution (HRA): $ _____

FSA Enrollment Effective Date: _____
Semi-monthly (24) pay periods per year

Per pay period election: $ _____

Annual Election: $ _____

Dependent Care FSA Enrollment Effective Date: _____
Semi-monthly (24) pay periods per year

Per pay period election: $ _____

Annual Election: $ _____

Employee Signature

FSA/DCFSA

I hereby authorize the appropriate payroll reductions as my contribution(s) to the Cafeteria Plan until changed by me in writing. I recognize that such payroll reductions shall be adjusted automatically in the event of a change in the insurance premiums of the benefits I have selected. I will only use the Flexible Spending Account (including the use of a Debit Card) for eligible expenses under the plan, and understand I will be responsible to pay for any transactions not allowed by the plan. In addition, I authorize the release of medical and account information to my spouse (if applicable).

HRA

I authorize National Benefit Services, LLC to initiate credit entries and, if necessary, debit and adjustment entries for any credit entries and adjustments made in error to my account indicated above and the financial institution named above.

I, the undersigned, attest that to the best of my knowledge these statements are complete and true.

Employee Signature: _____

Date: _____