BASIC FLEX

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: _____

Participant First Name: _____ Last Name: _____

Social Security #: ___ - __ - ____ Date of Birth: _____/_____/_____

Address: _____

City, State, Zip: _____ Phone Number: _____

E-mail Address: _____ (Notification of direct deposit payments are only sent via e-mail)

GENERAL PURPOSE REIMBURSEMENT ACCOUNT (Medical, Dental, Vision)

☐ I elect to participate (not to exceed employer limit of $_____)

$_____ per pay x_____(# of pays CY) = $_____ Annually (do not round)

☐ *I am NOT enrolled in a health insurance plan with a deductible of $1350/$2700 or more.*

☐ I elect NOT to participate

Employer Use

Please complete for mid-year enrollments

Date of first deduction: _____

Eligibility date: _____

LIMITED PURPOSE REIMBURSEMENT ACCOUNT (Dental & Vision Only)

☐ I elect to participate (not to exceed employer limit of $_____)

$_____ per pay x_____(# of pays CY) = $_____ Annually (do not round)

☐ *I am enrolled in a health insurance plan with a deductible of $1350/$2700 or more.*

☐ I elect NOT to participate

DEPENDENT CARE ACCOUNT

☐ I elect to participate (not to exceed $5000 or $2500 if married filing separately)

$_____ per pay x_____(# of pays in plan year) = $_____ Annually (do not round)

☐ I elect NOT to participate

DIRECT DEPOSIT (not all employers allow direct deposit as a reimbursement option)

☐ Use account information on file ☐ Use account information below ☐ No Direct Deposit

☐ Checking account OR ☐ Savings account

Check Example

A123456789 A0000123456 A1234

routing number account number check number

Financial Institution (name of bank): _____

Routing Number (always 9 digits): _____ Account Number: _____

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan description (SPd). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPd. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____