Flexible Benefit Plan Enrollment Form

Please Print

Employee Name ____ **Soc. Sec. #**________-______-___________

Employer ____ **Branch/Location**_________________________

Plan Year: _______/_______/_______ to _______/_______/_______ Number of payroll deductions:___________

Date of first deduction: ________________

Ia. Group Insurance Premiums:

Group insurance premiums will be deducted pre-tax automatically. Contact the benefit representative at your employer if you have questions regarding your group insurance premiums.

Ib. Independent Premium Feature:

I understand this is for independent health insurance premiums only.
Do not complete this section for your group health insurance premium through your employer.

I elect $_____________ x_____________=$____________ for independent premiums for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

II. Dependent Care Reimbursement Account:

I elect $_____________ x_____________=$____________ for dependent care expenses for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

III. Medical Reimbursement Account:

I elect $_____________ x_____________=$____________ for reimbursable medical expenses for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

Limited Purpose FSA

☐ By checking this box, I understand my Medical Reimbursement Account becomes a Limited Purpose Medical FSA because I participate in a HSA qualified health plan and contribute to my HSA account. I understand my Limited Pupose FSA can only reimburse vision & dental expenses.

Waiver

☐ I do not want to participate in the Flexible Benefit Plan (areas Ib, II, & III above). My Employer has offered me the opportunity to enroll and I am declining to participate for the above plan year.

I understand that my employer will deduct my election in equal amounts from my paycheck throughout the plan year. If at the end of the plan year the total declared reduction in my compensation exceeds the substantiated expenses, I understand that the remainder will become the property of my employer. I also understand that I will have an opportunity to make a new election, if I so desire, prior to the beginning of each subsequent plan year, in accordance with the procedures described in the Plan Document. By affixing my signature below, I certify that I have examined this Agreement and understand and agree to comply with the terms of the plan and applicable code sections of the Flexible Benefit Plan. All amounts listed will be incurred (meaning having a date of service) within the Flexible Benefit Plan Year. I also understand that Diversified Benefit Services, Inc. is not engaged in giving tax or legal advice and that I have consulted with my tax accountant on the appropriateness of the plan for me. I also understand that my monthly Social Security retirement benefit, if I receive one, may be reduced slightly by contributing pre-tax dollars to a Flexible Benefit Plan. Also, by providing an electronic mail address (e-mail), consent is given to receive unencrypted information regarding my FSA reimbursement account, including claims and personal health information, in electronic form at the e-mail address provided.

Employee Address: ____

City, State, Zip:____ Employee #: ______________________

Daytime Telephone: (_____) ______________________ e-mail: ________________________________

Employee Signature:____ Date: ________________________

Diversified Benefit Services, Inc.

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