

EMPLOYEE INFORMATION: (Completed by Employee)			
Name: _____			
Email: _____			
SSN: _____			
Address: _____			
City: _____		Date of Hire: _____	
State: _____		Zip Code: _____	
Phone: _____	Home _____	Work _____	Date of Birth: _____

ENROLLMENT INFORMATION: (Completed by HR)	
Date of Plan Entry: _____	
Date of First Payroll Deduction: _____	
Assigned Payroll Schedule: _____	
Total Number of Pay Periods: _____	
Verified Per Pay Contribution: _____	MED / DEP
Verified Annual Election: _____	/

I authorize my employer to make the following salary reductions: Indicate below the options in which you would like to participate.

Flexible Spending Reimbursement Account:*

- | | |
|----------------------------|-------------------------------------|
| 1. Deductibles and Co-pays | 4. Non-cosmetic Dental Procedures |
| 2. Eye Exams and Glasses | 5. Vitamins and Supplements are not |
| 3. Prescription Drugs | |

*Please visit www.mycafeteriaplan.com for a list of eligible expenses.

A. Total Per Pay contribution:	A. \$ _____
B. Total number of pay periods in plan year:	B. _____
C. Total Annual Election: Line A multiplied by line B (Maximum allowed: _____)	C. \$ _____

Dependent Daycare Reimbursement Account: Eligible daycare expenses for eligible dependents

- | | |
|--|--|
| 1. If married, your spouse must also be employed | 5. Dependent must reside in your household the majority of the |
| 2. Age limit for dependent children: 12 years of age | 6. Tuition expenses for K-12 school are not eligible |
| 3. May be used for elderly care if they meet the dependent requirement as defined by the IRS | |
| 4. Maximum Allowed: \$5,000 if single or married filing jointly, \$2500 if married filing separately | |

D. Total Per Pay contribution:	G. \$ _____
E. Total number of pay periods in plan year:	H. _____
F. Total Annual Election: Line D multiplied by line E (Maximum allowed: See #4 above)	I. \$ _____

I understand that:

I cannot change this election during the plan year unless I have a change in status as defined by the Internal Revenue Code and Regulations.

Any amount remaining Dependent Daycare reimbursement account and any amount over \$550 in my Health and Limited Health Flexible Spending Account at the end of the year will be forfeited.

My Social Security benefits may be reduced by this election.

This election replaces any previous elections and will terminate on the earlier of:

- (1) the end of the plan year.
- (2) when I am no longer being paid compensation in an amount at least equal to my total salary reduction.
- (3) termination of the plan.
- (4) termination of employment.

My Employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I am required to keep sufficient documentation (e.g., invoices and receipts) for all expenses and may be asked to submit such documents to myCafeteriaPlan.

I hereby authorize my employer to payroll deduct any amount equal to the total of all unsubstantiated flex card transactions as reported by myCafeteriaPlan.

Signature: _____

Date: _____