

Date of Plan Entry: Date of First Payroll Deduction: Assigned Payroll Schedule: Total Number of Pay Periods: Total Number of Pay Periods: Werlfied Per Pay Contribution: / Verified Per Pay Contribution: / Verifi	EMPLOYEE INFORMATION: (Completed by Employee)		ENROLLMENT INFORMATION: (Completed by HR)	
Address: City: Date of Hire: State: Lip Code: Phone: Home Work Date of Birth: Lip Code: Verified Per Pay Contribution: Jeductibles and Co-pays 2. Eye Exams and Glasses 3. Prescription Drugs **Please visit www.mycafeteriaplan.com for a list of eligible expenses.* A. Total Per Pay contribution: B. Total number of pay periods in plan year: C. Total Annual Election: Line A multiplied by line B. [Maximum allowed: J. Age limit for dependent children: 12 years of age 3. May be used for eliedry care if they meet the dependent requirement as defined by the IRS A. Moy be used for eliedry care if they meet the dependent requirement as defined by the IRS A. Moy be used for eliedry care if they meet the dependent requirement as defined by the IRS D. Total Per Pay contribution: C. Total Annual Election: Line D multiplied by line B. [Maximum allowed: J. If married, your spouse must also be employed J. Indian expenses for K-12 school are not eligible J. Maximum Allowed: \$5,000 if single or married filing jointly, \$2500 if married filing separately D. Total Per Pay contribution: C. Total Annual Election: Line D multiplied by line B. [Maximum allowed: \$5. Dependent must reside in your household the majority of the majority of the meet the dependent requirement as defined by the IRS J. Total Annual Election: Line D multiplied by line E. [Maximum allowed: See IH4 above) Lip Contained the Lip Cont	Name:		Date of Plan Entry:	
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State:				MED / DEP
Phone: Home Work Date of Birth: Verified Annual Election: /			Verified Per Pay Contribution:	/
Lauthorize my employer to make the following salary reductions: Indicate below the options in which you would like to participate. Flexible Spending Reimbursement Account:*				/
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