

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:

Independent Insurance Premiums such as Individual Dental and Vision Insurance Policies or Medicare Part B & D (Ineligible premiums include: health policies, long term care, and any type of group insurance policy.)
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)

IV. Other Contribution:

V. 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 unused funds may become the property of my employer depending on the provisions of the plan. 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.

Home Address: _____

City, State, Zip: _____ Employee #: _____

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

Employee Signature: _____ Date: _____



DI~~V~~ERSIFIED BENEFIT SER~~V~~ICES, INC.
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