



Election Form

Date: _____
 FAX - # Pages: _____

Company Name: _____

Effective Date of Election: _____ Date of Hire: _____

Employee Name: _____ SSN: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____ E-mail: _____

Enter Deductions per Pay Period

	Pre-Tax Amount Per Pay Period	Pay Period Frequency (W, B, S, or M*)	First Payroll Date Affected
<i>Employee Health Insurance Premium Account</i>			
▪ Health	\$ _____	_____	_____
▪ Dental	\$ _____	_____	_____
▪ Vision	\$ _____	_____	_____
** Flexible Spending Account (FSA) \$ _____ annual election	\$ _____	_____	_____
Dependent Care Spending Account \$ _____ annual election	\$ _____	_____	_____
Limited Scope Flexible Spending Account	\$ _____	_____	_____

Remember, when your needs change, Flex125 does too! You can change your premium elections any time you have a qualifying event that would change the status and/or premium amount of your employee insurance (i.e. marriage, divorce, birth or death of a child, death of a spouse, adoption or change of employment by spouse).

* Pay Period Frequency: W = Weekly; B = Biweekly; S = Semi-monthly; M = Monthly

** If you have a HSA account, you are only eligible to participate in a limited scope FSA if offered by your employer.

I acknowledge that I am authorizing the company to deduct equal amounts from my paychecks to collect the designated pre-tax column above. I recognize that these selections constitute a deliberate binding decision on my part that may not be changed until the enrollment period for the next plan year or if I experience a change in status.

Employee Signature: _____ Date: _____

— OR —

I elect **NOT** to participate in any portion of the Flex125 plan. (i.e. Premium, FSA, Dependent Care, Limited Scope).

Employee Signature: _____ Date: _____

