FLEX 125 Election Form

Contact Us Today!
www.myflexinfo.com

Date: _____
Fax- # of Pages: _____

Please follow the steps below to thoroughly and accurately complete this form.

Step 1: Personal Information

Company Name: _____

Effective Date of Election: _____ Date of Hire: _____

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

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

Phone Number: _____ Fax Number: _____ Email Address: _____

Step 2: Enter Deductions Per Pay Period

Employee Health Insurance Premium Account		Pre-Tax Amount Per Pay Period	Pay Period Frequency *(W, B, S or M*)*	First Payroll Date Affected
• Health		$		
• Dental		$		
• Vision		$		
• Other		$		
Flexible Spending Account (FSA)**	$ Annual election	$		
Limited Scope Flexible Spending Account**	$ Annual election	$		
Dependent Care Spending Account	$ Annual election	$		

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**

Step 3: Acknowledgement and Signature

☐ 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: _____