

# Benefit Plan Participation Form



Employer: \_\_\_\_\_

Plan Year: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

## Initially enroll or annually re-enroll in the Cafeteria Plan

Plan Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Participant Data (All fields are required)

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street City State Zip

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
mm/dd/yyyy

### Initial Enrollment

I elect to reduce my compensation for each pay period during the plan year (or during such a portion of the year as remains after the date of this agreement) and redirect such dollars into the Benefit Plan as set forth below.

- Medical Flexible Spending Account
- Dependent Care (Day/Childcare) Spending Account

Annual Election	Number of Pay Periods	Per Pay Period Deduction

### Signature and Authorization

I hereby certify I have read and understand the Terms and Conditions of this Plan which appear at the link <http://goo.gl/AXVASm> and in the Summary Plan Description and agree to abide by said Terms and Conditions. If waiving participation, I hereby certify I fully understand the benefits available to me under this Cafeteria Plan.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date