DIVERSIFIED BENEFIT SERVICES, INC.
Excellence in Benefit Management Solutions

# Flexible Benefit Plan Enrollment Form

*Please Print*

Employee Name _____ Social Security # _____-_____ - _____

Home Address _____

City _____ State _____ Zip_____

Daytime Telephone _____ Email _____

Employer Name _____ Branch/Location _____

Benefit Plan Year _____/_____/_____ to _____/_____/_____ Number of Payroll Deductions_____

Date of First Deduction _____/_____/_____ Effective Date _____/_____/_____

## Health Care FSA (HCFSA)

I elect $ _____ x _____ = $ _____ for reimbursable medical expenses for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

## Dependent Care FSA (DCFSA)

I elect $ _____ x _____ = $ _____ for reimbursable dependent care expenses for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

## Premium Reimbursement Account (PRA)

(Do not complete this section for your group health insurance premiums through your employer as they are to be deducted pre-tax automatically.)

I understand this account can be used for individual dental/vision and Medicare Part B and D insurance premiums only.

I elect $ _____ x _____ = $ _____ for individual premiums for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

## Waiver

☐ I do not want to participate in the Flexible Benefit Plan (areas listed 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 (email), 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.

**Employee Signature** _____ Date _____