

# FlexChoice125

## ENROLLMENT FORM

PLAN YEAR: \_\_\_\_\_ to \_\_\_\_\_

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

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

DATE OF BIRTH: \_\_\_\_\_ DATE OF HIRE: \_\_\_\_\_

DIVISION/LOCATION (if applicable): \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

**Yes**, I want to participate in the plan and receive the benefits as shown below. I have read the Salary Reduction Disclosure and understand that I will receive a Summary Plan Description to be given to me by my company, operating pursuant to the state laws of California.

**No**, I do not wish to Participate. The plan and its benefits have been explained to me. I understand that if I elect not to participate, any applicable contributions shall be paid with after-tax earnings. I understand that if I do not participate now, I can enter the plan only at the beginning of the next plan year, or during the current plan year only upon a change in family status, as described in the Summary Plan Description.

**I hereby make the following election regarding the benefits available to me under the Flexible Benefit Plan. I am further making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, such amounts to be deducted in approximately equal sums from my regular pay check during the coming plan year.**

*Any Group Insurance or Supplemental Insurance premiums paid by the employee, that qualify for the Cafeteria Plan, will be automatically included in the Plan on a pre-tax basis unless you see Human Resources and sign an opt-out form.*

**DEPENDENT CARE ASSISTANCE:** \$ \_\_\_\_\_ total per pay period/or specify  
The maximum monthly amount under the Cafeteria Plan is **\$416.66**. (\$ 208.33 for a married person filing a separate return.).

**UN-REIMBURSED (OUT-OF-POCKET) HEALTH CARE ACCOUNT:** \$ \_\_\_\_\_ total per pay period/or specify  
These are tax-free dollars set aside to pay for eligible expenses not covered by your Insurance Plans. The maximum monthly amount under the Cafeteria Plan is \_\_\_\_\_ (Refer to your Plan Brochure or SPD).

**INDIVIDUALLY OWNED HEALTH INSURANCE:** \$ \_\_\_\_\_ per pay period/or specify  
Please note that only Health Insurance policies owned by the employee are covered; **not life insurance policies nor spouse's group insurance or long-term care policies.** **IMPORTANT: PLEASE ATTACH POLICY DECLARATION PAGE** (check your Summary Plan Description to determine if this is a Plan benefit)

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_