PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: _____

Participant First Name: _____ Last Name: _____

Social Security #: ☐☐☐-☐☐-☐☐☐☐ Date of Birth: _____ /_____ /_____

Address: _____

City, State, Zip: _____ Phone Number: _____

E-mail Address: _____ (Notification of direct deposit payments are only sent via e-mail)

Pay Period: ☐ Weekly ☐ Semi-Monthly (twice a month) ☐ Bi-Weekly (every other week) ☐ Monthly

PREMIUM CONTRIBUTIONS

☐ I elect to participate (check all that apply)

☐ Health Insurance ☐ Group Life Insurance ☐ Disability Insurance ☐ Dental Insurance

☐ HSA Contributions ☐ Vision Insurance ☐ Other(s)_____

The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.

☐ I elect NOT to participate

EMPLOYER USE

Please complete for mid-year enrollments

Date of first deduction:

_____

Eligibility date:

_____

MEDICAL REIMBURSEMENT ACCOUNT

☐ I elect to participate (not to exceed employer limit of $_____)

$ _____ per pay x _____ (# of pays in plan year) = $ _____ Annually (do not round)

☐ *Is this Medical Reimbursement Account a Limited Purpose Account (see page 6)*

☐ I elect NOT to participate

DEPENDENT CARE ACCOUNT

☐ I elect to participate (not to exceed $5000 or $2500 if married filing separately)

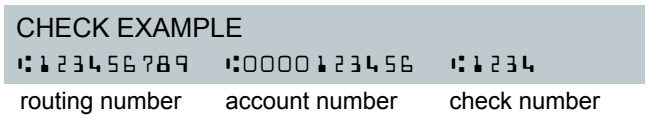
$ _____ per pay x _____ (# of pays in plan year) = $ _____ Annually (do not round)

☐ I elect NOT to participate

DIRECT DEPOSIT (not all employers allow direct deposit as a reimbursement option)

☐ Use account information on file ☐ Use account information below ☐ No Direct Deposit

☐ Checking account OR ☐ Savings account



Financial Institution (name of bank): _____

Routing Number (always 9 digits): ☐☐☐☐☐☐☐☐☐ Account Number: _____

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____