

# Flexible Benefit Plan Enrollment Form

**Please Print**

**Employee Name** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Employer** Hortonville Area School District **Branch/Location** \_\_\_\_\_

**Plan Year:** 10 / 01 / 11 to 09 / 30 / 12 Number of payroll deductions: 17

Date of first deduction: 10/15/2011

**Ia. Group Insurance Premiums:**

Group insurance premiums will be deducted pre-tax automatically. Contact the benefit representative at your employer if you have questions regarding your group insurance premiums.

**Ib. Independent Premium Feature:**

I understand this is for independent health insurance premiums only.

**Do not complete this section for your group health insurance premium through your employer.**

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

**II. Dependent Care Reimbursement Account:**

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

**III. Medical Reimbursement Account:**

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

**IV. Other Contribution:** \_\_\_\_\_

**V. Waiver**

- I do not want to participate in the Flexible Benefit Plan (areas Ib, II, & III 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 the remainder will become the property of my employer. 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 (e-mail), 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 Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Employee #: \_\_\_\_\_

Daytime Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ e-mail: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**DI**VERSIFIED BENEFIT SERVICES, INC.  
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