

SECTION 125 FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

Plan Year Beginning ____ / ____ / ____ Ending ____ / ____ / ____ Check one: New Enrollment Re-enrollment

Employer: _____		Division (if applicable): _____	
Employee Name: _____		Soc. Sec. No: _____	
Last	First	MI	
Date of Birth: _____		Home Address: _____	
City: _____	State: _____	Zip: _____	E-mail: _____

Payroll Frequency: Weekly (52) Bi-weekly (26) Semi-monthly (24) Monthly (12) Other _____

Date of Hire: ____ / ____ / ____ Effective Date: ____ / ____ / ____

Paycheck Deductions Start On: ____ / ____ / ____ Number of Deductions in the Plan Year: _____

Benefit Election Authorization or Waiver

Enter the annual amount of your allocation(s) for the Plan Year to the account(s) of your choice and divide by the number of paychecks you receive during the Plan Year to arrive at the amount of your salary reduction each paycheck.

Benefit Elections:	Annual Amount	No. of Paychecks	Per Paycheck Reductions
A. Health Care Flexible Spending Account (FSA) <small>(cannot exceed your Plan's maximum)</small>	\$ _____ ÷	_____	= \$ _____
B. Dependent Care Flexible Spending Account (FSA) <small>(*This amount cannot exceed \$5,000 per family per calendar year).</small>	\$ _____ * ÷	_____	= \$ _____
Total Authorized Pre-Tax Salary Reductions	\$ _____		\$ _____

Waiver of Participation in Health FSA and Dependent Care FSA.
After careful consideration, I have chosen not to participate in the FSAs for the current Plan Year.

C. **Premium Payment (Pre-Tax)**
Contributions to the Employer-Sponsored Benefit Plan(s). **

PER PAY PERIOD \$ _____

Waiver of Participation in Pre-tax Premium Payment.
After careful consideration, I have chosen not to participate in the pre-tax premium portion of the Plan.

**This amount can be automatically increased or decreased during the Plan Year to correspond with increases or decreases in the amount of Employee contributions required by Employer to its benefit plans.

By signing below, I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified.
- I understand that I am not permitted to change my elections during the Plan Year unless the change is on account of and consistent with current recognized IRS regulations and change in status events.
- I also understand that any funds left in my Dependent Care and/or Health FSAs at the end of the Plan Year will be forfeited in accordance with IRS Regulations.

Employee Signature: _____	Date: _____
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Infinisource, Inc. has incorporated the HIPAA Privacy Requirements to reflect our organization's business practices regarding your FSA coverage.

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