Cafeteria Plan—Section 125 Enrollment Form

APPLICANT INFORMATION					
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)		SEX	DATE OF BIRTH	SOCIAL SECURITY #	
STREET ADDRESS		CITY	STATE	ZIP CODE	EFF DATE
HOME PHONE	WORK PHONE	EMAIL ADDRESS			

TYPE
☐ New Enrollment ☐ Change

If Change, please mark one of the following:
☐ Marriage ☐ Divorce ☐ Birth/Adoption ☐ Change of Spouse's Employment ☐ Death of Spouse or Child

☐ Change in Eligibility Status Other _____

EMPLOYEE BENEFIT OPTIONS

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction period cost and the amount paid by the pre-tax reduction or after-tax deduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

	Salary Reduction per pay period
PREMIUM CONVERSION	
Group Health Insurance	$_____
Group Dental	$_____
Vision Insurance	$_____
ANNUALIZED DEDUCTION TOTAL	
Group Health Insurance	$_____per plan year
Group Dental	$_____per plan year
Vision Insurance	$_____per plan year

	Salary Reduction per pay period
REIMBURSEMENT ACCOUNTS	
FSA Medical Expenses	$_____
FSA Dependent Care	$_____
ANNUALIZED DEDUCTION TOTALS:	
FSA Medical Expenses	$_____per plan year
FSA Dependent Care	$_____per plan year

EFFECTIVE DATE: _____

I hereby authorize to **ELECT ( ) DECLINE ( )** participation and direct my employer to reduce my salary in the amount necessary to pay for the benefit coverages listed above and understand that this amount will not be subject to Social Security or Federal Income Tax withholding, which may result in a reduction of future Social Security benefits to which I may be entitled. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date of the Plan. I further authorized future adjustments in the amount of the salary reduction in the event the cost of coverage in any program selected above under the heading PREMIUM CONVERSION is changed by the carrier during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed. I am aware that once I have elected to participate in this Plan, that I may not revoke my election until the end of the Plan Year with the exception of a Change in Family Status. I understand that my unused balance of the reimbursement accounts, if any, at the end of the Plan Year will be forfeited by me back to my employer.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as listed on the Status Change Matrix I received with the Summary Plan Description.

_____ _____

Signature Date

Return this form to: HealthSCOPE Benefits
P. O. Box 350
Little Rock, AR 72203

HealthSCOPE BENEFITS