

EMPLOYER PLAN SERVICES, INC. ENROLLMENT FOR EMPLOYEE CAFETERIA PLAN

Employer			Group No.		
Employee Last Name, First, MI			Social Security No.		
Street Address		City, State		Zip Code	
Date of Birth	Single <input type="checkbox"/>	Male <input type="checkbox"/>	Date of Hire		
Month	Day	Year	Married <input type="checkbox"/>	Female <input type="checkbox"/>	

Family Members:

Spouse's name _____ DOB _____
 Dependent's name _____ Relationship _____ DOB _____
 Dependent's name _____ Relationship _____ DOB _____
 Dependent's name _____ Relationship _____ DOB _____
 Dependent's name _____ Relationship _____ DOB _____
 Dependent's name _____ Relationship _____ DOB _____

Please select the benefits you wish to include in the Plan by completing the information requested below:

This election is for the initial period _____ through _____.

This election remains in effect until amended or terminated at the start of a new Plan Year.

TYPE OF ELECTION

DEDUCTION PER PAY PERIOD

ANNUAL DEDUCTION

Group Insurance Premiums **(((If Applicable)))**

Medical
Dental
Vision
OTHER

DEDUCTION PER PAY PERIOD

ANNUAL DEDUCTION

Unreimbursed Medical Expenses

Medical (annual max _____)

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Dependent Care Expenses

Child Care (annual max \$5000.00)

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I understand, in accordance with the plan provisions and tax laws, any funds in my account(s) I fail to use during the plan year will be forfeited. I understand that any disability payment made to me under the plan may be subject to Federal and/or State taxes.

I understand this election cannot be changed during the plan year except in the event of a change in my family status, such as but not limited to: death, divorce, marriage, birth or adoption, or termination of spouse's employment. I understand it is my responsibility to keep documented records in order to verify the reimbursements I receive. I hereby elect to include the coverage's selected above in my Cafeteria Plan and authorize my employer to redirect my pay in the amounts necessary to provide for these coverage's, as well as any changes in future contributions that may be required.

Signature _____ Date _____

Beneficiary _____

The Plan has been explained to me, and I **decline** to have my pay redirected for the coverage's listed above.

Signature _____ Date _____