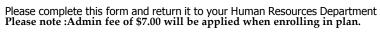
125 Cafeteria Plan Enrollment Form





1 Personal Information					
Employee Name (First Name, Last Name)			Company Nam	ne	
Street Address		City	State	Zip Code	Social Security Number
Employee Phone Number Date of Bir		th	Date of Hire (F	Required)	Email Address (Required to receive e-mail communications)
2 Benefit Elect	ion ☐ New Year Request	☐Waive Participatio	n		
If you are part of a company health insurance plan your premiums will automatically be paid pre-tax by payroll deduction. You may also choose any of the following benefits to add to your pre-tax deduction:					
Number of pay periods per year: (Required) Bi-weekly (26) Weekly (52) Semi-monthly (24) Monthly (12)					
☐ Health Flexible Spending: Must not exceed \$ 3,300/year as per IRS regulations ☐ Limited Health Flexible Spending (if you participate in an HSA you can only participate in a Limited FSA)		- 11	<u>. </u>	\$	Per pay period election (Required)
		Enrollment Effective D (Required)	ate	\$	Annual Election Per pay period election
		Enrollment Effective D (Required)	ate	\$ \$	(Required) Annual Election
Dependent Care Expenses: Maximum annual allowable election is \$5,000 per year OR \$2,500 per year if married and filing taxes separately				_\$	Per pay period election (Required)
		Enrollment Effective D (Required)	ate 	_ \$	_ Annual Election
3 Debit Card (I ☐ I already have a card and will continue	Health Care Exper	You will receive 1 card in additional card for a dep	endent, indicat	e their name here:	
to use it.	a card	For replacement card		nd/or additional depe website at my.nbsben	endent cards please contact HR or efits.com
4 Direct Deposit Request					☐ Checking Account ☐ Savings Account
Your Financial Institution					
Financial Institution Address					
IMPORTANT! Please attach a voided check with this form (not a deposit slip). Only for a savings account is a deposit slip acceptable. If you have Direct Deposit information on file it carries forward unless corrected or rescinded in writing by you. I (We) authorize National Benefit Services, LLC to initiate credit entries and, if necessary, debit and adjustment entries for any credit entries and adjustments made in error to my (our) account indicated above and the financial institution named above.					
Employee Signature					Date
5 Employee Signature I hereby authorize the appropriate payroll reductions as my contribution(s) to the Cafeteria Plan until changed by me in writing. I recognize that such payroll reductions shall be adjusted automatically in the event of a change in the insurance premiums of the benefits I have selected. I will only use the Flexible Spending Account (including the use of a Debit Card) for eligible expenses under the plan, and understand I will be responsible to pay for any transactions not allowed by the plan. In addition, I authorize the release of medical and account information to my spouse (if applicable).					
Employee Signature					