



Enrollment Form

Medical and/or Dependent Care Flexible Spending Arrangement

When completed, give a copy to your Human Resources Department and fax a copy to 125MAX (916)605-4013

Employee Data					
Employer Name:			Current Plan Year:		
Employee Name:			Social Security Number:		
Mailing Address:			Daytime Phone:		
City, State, Zip:			Evening Phone:		
E-mail Address:			Date of Hire:		
May 125MAX communicate with you via email? (i.e. HIPAA Privacy Notification, EOBs, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No					
List All Dependents (spouse, children, etc.)					
Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

Type of Election and Current Coverage		
Type of Election:	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Family Status Change (also include Change of Election Form)	
New Hire (only)	Date of Eligibility:	First Contribution (payroll date):
Current Health Coverages (Check all that Apply) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other:		

Flexible Spending Arrangement Participant Request	
Please indicate desired participation for the current Plan Year. This election may not be changed during the Plan Year unless a qualified family status change occurs.	
<p>Medical Expenses</p> <p><input type="checkbox"/> I <u>do</u> wish to participate <input type="checkbox"/> I <u>do not</u> wish to participate</p> <p><u>Check with your HR Manager for Plan minimum and maximum</u></p> <p>Plan Year Election: \$ _____</p> <p>Plan Year Maximum: \$ _____</p> <p>Plan Year Minimum: \$ _____</p> <p>This election is for eligible medical expenses for yourself and/or your dependents. Premium contributions should not be counted.</p>	<p>Dependent Care Expenses</p> <p><input type="checkbox"/> I <u>do</u> wish to participate <input type="checkbox"/> I <u>do not</u> wish to participate</p> <p><u>Check with your HR manager. for Plan minimum</u></p> <p>Plan Year Election: \$ _____</p> <p>Plan Year Maximum: \$ <u>5,000.00*</u></p> <p><i>*\$5,000.00 Is an IRS Imposed Calendar Year Maximum*</i></p> <p>Plan Year Minimum: \$ _____</p> <p>This election is for eligible dependent care expenses (daycare, childcare, or elder care). This election should not be used for medical expenses for your dependents.</p>

Employee Certification	
<p>I have read and understand the 125MAX Medical and/or Dependent Care Flexible Spending Arrangement Plan guidelines as outlined in the Enrollment Packet and I understand the restrictions that apply to eligible expense reimbursement requests. <i>Further, I understand that the above salary reduction request which will be allocated to my Flexible Spending Arrangement will be forfeited according to current plan provisions and tax laws if I do not incur and appropriately submit any eligible expenses within the Plan Year.</i> I certify the above information to be true and that the dependents that I intend to claim expense reimbursements for are legally dependent on me for their support as defined by current tax law. I agree to have my compensation reduced by the amounts indicated above. I understand that my election to reduce my compensation could affect my Social Security benefits and other wage-based social insurance programs. I further understand that the deduction elections indicated above will remain in effect for the entire Plan Year and cannot be changed or revoked unless I experience a qualified change in family status as defined by the law. I understand that my signature on this enrollment form constitutes a formal salary reduction agreement between my Employer and me.</p>	
Date:	Participant Signature: