Benefit Plan Participation Form

Employer: ______________________________

Plan Year: ____/_____/_____ to ____/_____/_____

Initially enroll or annually re-enroll in the Cafeteria Plan

Plan Effective Date: ____/_____/_____

Participant Data (All fields are required)

Employee Name: ______________________________ SSN: ______________
Last First M.I.

Address: ____
Street City State Zip

Email: ________________ Phone: ______________ Date of Birth: ____________
mm/dd/yyyy

Initial Enrollment

I elect to reduce my compensation for each pay period during the plan year (or during such a portion of the year as remains after the date of this agreement) and redirect such dollars into the Benefit Plan as set forth below.

	Annual Election	Number of Pay Periods	Per Pay Period Deduction
☐ **Medical Flexible Spending Account**			
☐ **Dependent Care Spending Account**			

Signature and Authorization

I hereby certify I have read and understand the Terms and Conditions of this Plan which appear at the link http://goo.gl/AXVASm and in the Summary Plan Description and agree to abide by said Terms and Conditions. If waving participation, I hereby certify I fully understand the benefits available to me under this Cafeteria Plan.

______________________________ ______________
Employee's Signature **Date**