Benefit Plan Participation Form

Employer:____________________________

Plan Year: Jan 1, 2021 to December 31, 2021

Participant Data (all fields are required)

Employee Name:____ SSN: _________________________

Address:____

Email:______________________________ Phone:______________________ Date of Birth:_____________

Initial or Annual 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 the agreement) and redirect such dollars into the Benefit Plan as set forth below.

Plan Name	Annual Election	Number of Pay Periods	Per Pay Period Deduction
Medical Flexible Spending Account			
Dependent Care Flexible Spending Account			
Limited Flexible Spending Account			

Signature and Authorization

I hereby certify I have read and understand the Terms and Conditions of The Plan which appear at the link https://onepointhro.com/documents.php 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 Signature **Date**