# FLEXIBLE BENEFITS PLAN

Payroll Effective Date _____

## Payroll Factory Flexible Spending Plan
## Enrollment Form

Company Name: _____

Name: _____ SS#: _____

Address: _____

Email Address: _____

1. **Group Insurance Premium Account**
   I authorize a salary reduction to pay my group premium contribution for myself and/or my dependents with pre-tax dollars.
   ***Your employer will provide the dollar amount.***
   **Initial:** _____

2. **Medical Related Reimbursement Account**
   Tax-free dollars set aside to pay for these expenses not covered by your insurance plan.(examples: Co-pays, prescription, X-Rays, etc.) As well as premiums paid out of pocket (medical, dental, vision, etc.) ***Annual limit = $2,550.00***
   **$** _____
   **Per Payroll**

3. **Dependent Care Reimbursement Account**
   You may set aside a maximum of $5,000.00 or $2,500.00 if married and filing separately per year for dependent care.
   **$** _____
   **Per Payroll**

4. **Individual Transit Benefits**
   A ride in commuter vehicle, transit pass, parking, bicycle communting
   **$** _____
   **Per Payroll**

_____ **Authorization**

I elect to participate in Employer's Flexible Spending Plan. I agree to have my gross salary reduced by the amounts entered above. I understand that this election is irrevocable for the plan year unless there is a change in family status, and that any unused balance in the account will be returned minus a $5.00 service charge.

_____ **Declination**

I hereby elect not to participate in this Flexible Spending Plan.

Employee Signature: _____ Date: _____

Marital Status: _____