

**FLEXIBLE BENEFITS PLAN
ENROLLMENT AND PAYROLL REDUCTION AUTHORIZATION FORM**

Please complete the following information accurately and completely with a ballpoint pen; print clearly. The information you provide should be current as to the date completed. All employees who have fulfilled the eligibility requirements to participate in the plan must complete all sections of the form. Please return this form to the **PAYROLL DEPARTMENT** prior to **DECEMBER 1, 2005**

SECTION I – GENERAL INFORMATION

SS Number	Last Name	First Name	MI
Date of Hire	Birth Date	M or F	
Number and Street		Additional Mailing Information	
City	State	Zip	

SECTION II – SALARY REDUCTION ELECTIONS

	Annual Election	Per Pay Election
Dependent Care Account	\$ _____	\$ _____
Medical Spending Account	\$ _____	\$ _____

In making this election the following is understood:

- My elections are irrevocable during the plan year unless I have incurred a qualified family status change.
- Any and all monies not claimed against 90 days after the end of the plan year will be forfeited.
- It is understood that I may not take tax benefits on my annual 1040 tax returns for those monies utilized in this plan.

_____ I accept participation _____ I decline participation

Name: _____ Date: _____