CAFETERIA PLAN ENROLLMENT FORM

Employer:	***Plan Year:***
Name:	***Employee ID: (SSN)*** DOB for H.S.A Only
Mailing Address:	***Phone Number:***
City: ***State:*** ***Zip:***	***Email Address:*** *Please provide an email address that is monitored regularly.*

❑**NO,** ***I do not wish to enroll in the Cafeteria Plan (Includes Pre-Tax Insurance Premiums, HSA, FSA or DCA withholdings).***
I understand that I cannot enroll at any other time during the plan year unless I experience a "Change in Status". I also understand that since I am not enrolling in the plan, my premium contribution for health insurance coverage will be deducted from my pay on an after-tax basis.

❑**YES,** ***I elect to enroll in the Plan, effective _____, and authorize my employer to reduce my pay by the following amount(s):***

1. "EMPLOYER SPONSORED" INSURANCE PREMIUMS

Monthly Salary Reduction for ALL insurance premiums (medical, dental, vision, etc.)	$

2. "INDIVIDUALLY OWNED" SUPPLEMENTAL INSURANCE PREMIUMS

**Cannot be an individually owned major medical policy, Medicare or COBRA premium. Call our office if you have questions on your plans eligibility.*

Monthly Salary Reduction for certain policies* (*not sponsored by your employer)*	$

3. HEALTH CARE/FLEXIBLE SPENDING ACCOUNT ANNUAL ELECTION

**The maximum employee contribution to the health care account (FSA) is capped at a $2,850 annual election. Your specific plan may still have a lower maximum contribution.*

Annual Salary Reduction for the health care/flexible spending account (FSA)	**TOTAL ANNUAL FSA ELECTION**	$

4. HSA CONTRIBUTIONS

Monthly election for my Health Savings Account coverage

Monthly Salary Reduction for the health savings account (HSA)	**TOTAL MONTHLY HSA ELECTION**	$ **0**

5. DEPENDENT DAYCARE ACCOUNT ANNUAL ELECTION

**Please note- Dependent day care expenses include expenses incurred for the care of dependent children under the age of 13 so that you and your spouse can work, look for work or be a full-time student. School tuition may not be reimbursed. For handicapped dependents 13 and over, please contact Professional Benefit Services. The daycare election is capped at $5,000 per household.*

Annual Salary Reduction for the dependent daycare account (DCA)	**TOTAL ANNUAL DCA ELECTION**	$

❑**I understand** that by electing to pay for my health insurance coverage through the Cafeteria Plan, my premiums will automatically be deducted from my pay on a before tax basis. I authorize the employer to process these premium contributions as an automatic plan reimbursement throughout the plan year.

❑**I understand** that the salary reduction I have elected for health expenses are recorded separately from the salary reduction for dependent care costs or premiums. If there is money recorded in one account at the end of the year, it is not transferable to meet expenses in the other category.

❑**I understand** that I cannot suspend, increase or decrease my salary reductions during the plan year unless I experience a "Change in Status" as described in federal regulations.

❑**I understand** that all claims paid must be for services incurred during the current plan year as stated in the plan document.

❑**I understand** that any money remaining in my cafeteria plan account(s) above $500 at the end of the plan year may be forfeited. I have received a written explanation of the cafeteria plan. I understand that the employer cannot be responsible for any tax liabilities that may subsequently occur as a result of my plan participation.

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This Plan Administered by Professional Benefit Services, Inc.
Phone: (800)982-2012, (503)371-7622 Fax: (503)364-6901, (866)248-9742
Email: cafeteria@profben.com Website: www.profben.com

❑ **I understand** that if I have a benefits card, it must only be used for eligible expenses not being reimbursed by any other health plan, and I will save all card transaction information because my account may be audited at any time.

❑ **I understand** that I may not participate in an HSA under this plan unless I am covered by a High Deductible Health Plan (as described in the Plan Documents), and am not covered under any other health plan that is not a High Deductible Health Plan, and am not entitled to benefits under Medicare.

❑ **I understand** that I can suspend, increase or decrease my salary reductions for my Health Savings Account contribution prior to the first of any month for the next following month.

Your Signature:	Date:
Company Authorization:	Date: