Cafeteria Plan Enrollment Form

July 1, 2021 - June 30, 2022 Plan Year

EMPLOYEE INFORMATION

Today's Date: ______________________________ Company Name: ______________________________

Employee Name: ____ Date of Hire: ____________________

Address: ____

Social Security Number: ______________________________ Date of Birth: ______________________________

Payroll Frequency

Payroll Effective Date:

Email Address:

PREMIUMS

I agree to have the following health premium deductions made from my salary on a pre-tax basis.

☐Medical ☐Dental ☐Vision

FLEXIBLE SPENDING ACCOUNT (FSA)

☐ Medical Expenses Annual Election:_______________($2,750 maximum)

☐ Dependent Care Expenses Annual Election:_______________($5,000 maximum or $2,500 if married filing separate)

I authorize the adjustment to my annual base salary based on my elections above. By signing and submitting this form, I am indicating that I understand the following:

- I am making a binding election for the Plan Year. I cannot change or terminate my benefit elections during the Plan Year unless I have a qualified status change (e.g., marriage, divorce, death, termination of employment), as defined under IRS regulations, and notify the plan administrator and submit the appropriate change forms within 30 days of the occurrence of the change.
- Insurance premium deductions under this Agreement will continue for each pay period until the Agreement is revoked, amended or otherwise terminated.
- If the premiums for the elected benefits are changed while this agreement remains in effect, my compensation reduction will be adjusted automatically to reflect that increase or decrease.
- Medical and dependent care expenses incurred prior to my enrollment effective date are not eligible expenses. Likewise, expenses incurred following a termination of employment will not be eligible for reimbursement. Employees have 90 days from the date of termination to request reimbursement for expenses incurred in the current Plan Year prior to his/her date of termination.
- I will have the opportunity to change my benefit elections prior to the beginning of the next Plan Year, effective as of the beginning of that next Plan Year.

Signature:____ Date: ______________________________

DECLINING COVERAGE

The benefits of the Cafeteria Plan have been presented and explained to me and I decline to participate. I understand that I cannot enroll in the Plan until the beginning of the next Plan Year or until I have a Change in Status that would allow me to change my election.

Signature:____ Date: ______________________________

CPI
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