125 Cafeteria Plan Enrollment Form

Please complete this form and return it to your Human Resources Department

1 Personal Information

Employee Name (First Name, Last Name) | Company Name

Street Address | City | State | Zip Code | Social Security Number

Employee Phone Number | Date of Birth | Date of Hire (Required) | Email Address (Required to receive e-mail communications)

2 Benefit Election

☐ Initial Request ☐ New Year Request ☐ Waive Participation

If you are part of a company health insurance plan your premiums will automatically be paid pre-tax by payroll deduction. You may also choose any of the following benefits to add to your pre-tax deduction:

Number of pay periods per year: (**Required**) ☐ Bi-weekly (26) ☐ Weekly (52) ☐ Semi-monthly (24) ☐ Monthly (12)

☐ Health Care Expenses:
Must not exceed $2,500/year as per IRS regulations

Enrollment Effective Date (Required)

$ **Per pay period election (Required)**

$ Annual Election

☐ Dependent Care Expenses:
Maximum annual allowable election is $5,000 per year OR $2,500 per year if married and filing taxes separately

Enrollment Effective Date (Required)

$ **Per pay period election (Required)**

$ Annual Election

3 Direct Deposit Request

☐ Checking Account
☐ Savings Account

Your Financial Institution

Financial Institution Address

Account Number | Routing Number

IMPORTANT! Please attach a voided check with this form (not a deposit slip). Only for a savings account is a deposit slip acceptable. If you have Direct Deposit information on file it carries forward unless corrected or rescinded in writing by you.

I (We) authorize National Benefit Services, LLC to initiate credit entries and, if necessary, debit and adjustment entries for any credit entries and adjustments made in error to my (our) account indicated above and the financial institution named above.

Employee Signature | Date

4 Employee Signature

I hereby authorize the appropriate payroll reductions as my contribution(s) to the Cafeteria Plan until changed by me in writing. I recognize that such payroll reductions shall be adjusted automatically in the event of a change in the insurance premiums. I will only use the Flexible Spending Account for eligible expenses under the plan, and understand I will be responsible to pay for any transactions not allowed by the plan. In addition, I authorize the release of medical and account information to my spouse (if applicable).

Employee Signature | Date

PO Box 6980, West Jordan, UT 84084 • (855) 399-3035 • Fax (844) 438-1496 • www.participant.nbsbenefits.com