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CAFETERIA/SECTION 125
FLEXIBLE SPENDING ACCOUNT
EMPLOYEE CONFIDENTIAL ENROLLMENT FORM

Section 125 of the Internal Revenue Code allow participants in a Cafeteria Plan to **increase** their take home pay by electing to pay medical and childcare costs from money placed inside their Cafeteria account. Participants may also pay for their contributions to medical, dental, and certain other benefit programs with **before** tax dollars. This election form, completed each plan year, is used by participants to elect what amounts they want to place in their Cafeteria account during the Cafeteria plan year.

COMPANY NAME: PHONE: ( ) -

EMPLOYEE NAME: SS#: - -

ARE YOU:
AN OFFICER OF THE CO.: YES NO AN OWNER OF THE CO.: YES NO

HOME ADDRESS:
Street/Apt # City State Zip Code

HOME PHONE: ( ) - EMAIL:

DATE OF BIRTH / / MARRIED: YES NO SEX MALE FEMALE

OF PAY PERIODS **PER YEAR**: GROSS PAY **PER PAY PERIOD**:

EMPLOYEE ELIGIBILITY DATES FOR THE **CAFETERIA PROGRAM**:
* New hires – 1st of the month after eligibility.

1. From your **PAYCHECK**, how much do you have deducted **PER PAY PERIOD** for:

ELIGIBLE PREMIUMS:

A. Group Medical Insurance $______________________

B. Group Dental Insurance $______________________

C. Group Disability $______________________

D. Other Eligible Premiums $______________________
(e.g. Supplemental)

These are your contributions to the premiums that are paid to the insurance company by your employer.

Premium Only Sign Here (If participating in Unreimbursed Medical/Daycare please sign back of form):

A) Election To Complete Form Every Year: Signature____________________________________Date________

B) Election for all future years: By signing below I agree to make an election, for this year and **all future years**, to have all eligible premiums I am required to pay relating to company sponsored welfare benefit plans processed through my Cafeteria/Section 125 account. I understand that the premium amounts can change from year to year and that said amounts will continue to be deducted from my pay and processed through my Cafeteria/Section 125 account maintained by United Group Programs, Inc. **I further understand that I do not have to sign below** and can complete a new Cafeteria election form each year.

Therefore, my signature below states that if I choose to revoke this ongoing election, it must be done in writing prior to the beginning of each successive plan year unless a specific exception applies to me as explained on the front of this form.

Signature____Date__________

2. **UNREIMBURSED MEDICAL:** Estimate your uninsured Medical costs per paycheck. Keep in mind you may have out-of-pocket expenses over and above what you're insurance company pays for the following:

- Health/Dental Insurance Deductibles
- Vision care (eye-exams, contacts, eyeglasses)
- Routine exams (OBGYN, school physicals, etc.)
- Prescription Drugs (including Birth Control)
- Coinsurance (usually 20% or 30% of covered charges)
- Routine dental exams and cleaning, X-Rays, etc.
- Braces and retainers, orthodontic, etc.
- Fillings, crowns and bridges, etc.

EMPLOYEE BUDGET
PER PAYCHECK:

$_____________

Plan year may not coincide with calendar year. The amount listed above will continue to be deducted until the end of the **PLAN** year.

The above are just a few examples of out-of-pocket expenses that can be budgeted together and used interchangeably**.**
Please note: In most circumstances, claims must first be submitted to your insurance carrier. When you receive an Explanation of Benefits (EOB), attach a copy to the claim form.
When an EOB is not applicable, (e.g. co-payments, vision care, and other non-covered expenses), please submit receipt.

3. **DAY CARE:** If you are a single parent or your spouse works, how much do you pay for dependent day care for children 12 years or younger?

EMPLOYEE BUDGET
FOR DAY CARE
PER PAYCHECK:

$_____________

Please note: Form 2441 should be completed when filing your individual 1040 Tax return. Please consult your Tax Advisor for details.

The above amounts are being selected for an entire plan year and may only be changed for certain changes in family status. These include:

***Marriage**	***Divorce**	***Death of family member**
***Birth**	***Adoption**	***Spouse's employment termination**
***Part time to full time**	***Full time to part time**	***Leave of absence**

***Change in my, or spouse's health coverage attributable to spouse's employment**

My company's Flexible Benefit Program has been explained to me and I understand that I cannot (except under certain specific exceptions), change or revoke my election until open enrollment for the next Plan Year. The exceptions pertain to a valid change in status as listed above. I further understand that the total amount deducted for the reimbursement accounts must be used in that plan year or forfeited under the terms of the Cafeteria plan and that participation in the Flexible Benefit Program may mean that I will be paying less Social Security tax, which could slightly reduce my benefits when I retire.

I understand the terms above and authorize my employer to release any information from my payroll records that may be necessary to complete this form.

Signature: ____________________________ Date: ________________________