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| Section 125 Plan Enrollment Form |
| Employer Division Effective Date

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| Employee’s Name (Last, First, Middle) Social Security Number

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| Street Address City State Zip

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| Date of Birth Gender Date Employed Dependent Coverage

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|       | [ ]  Male [ ]  Female |       |       |

**Status**[ ]  Married [ ]  Single [ ]  Widowed [ ]  DivorcedSpouse Name Social Security Number Date of Birth

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Dependent Name Social Security Number Date of Birth

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I authorize payroll deduction of $      from my earnings per pay period. I request that my salary be reduced as follows:

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| Premiums (medical, dental, etc.) | Automatic\* |
| Unreimbursed medical expenses | $      annually |
| Dependent care expenses | $      annually |
| **Total:** | $      annually |

\*Your employer has elected to deduct your insurance premiums on a pretax basis, unless written notification is received waiving this benefit.**Authorization**I certify the above information to be correct and true to the best of my knowledge, and that the children listed under “Dependent Coverage” qualify as my dependents under the plan (generally, for group health plan coverage, a dependent is your child who is under age 26 and for other benefits a dependent is an individual who depends on you for financial support and maintenance). I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited and not returned to me. I further understand that my elections will remain in effect for the entire plan year and cannot be revoked unless I experience a change in my status or termination of either my employment or my spouse’s employment.Signature Date

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**If you decline participation:**The benefits of the medical and dependent care Flexible Spending Accounts have been thoroughly explained to me and I decline to participate, but wish to have my premiums paid pretax. Signature Date

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