



PLEASE PRINT AND WRITE CLEARLY. INFORMATION BELOW IS USED TO ENSURE ACCURATE ENROLLMENT.

Employer Name: _____

Participant/Employee Name: _____ Social Security #: _____-_____-_____

Address: _____ Date of Birth: ____/____/____

City, State, Zip: _____ Phone Number: _____

E-mail Address: _____ (Notification of direct deposit payment is sent via e-mail)

Pay Period: Weekly Semi-Monthly (twice a month) Bi-Weekly (every other week) Monthly

PREMIUM CONTRIBUTIONS

- I elect to participate (check all that apply)
 Health Insurance Group Life Insurance Disability Insurance Dental Insurance

The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.

- I elect NOT to participate

DEPENDENT CARE ACCOUNT

- I elect to participate (not to exceed \$5000 or \$2500 if married filing separately)
\$ _____ Annually
 I elect NOT to participate

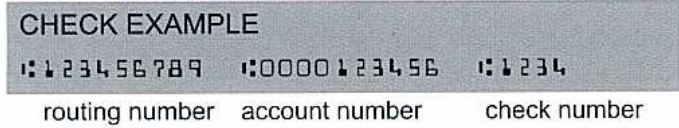
MEDICAL REIMBURSEMENT ACCOUNT

- I elect to participate (not to exceed employer limit of \$ _____)
\$ _____ Annually
 I elect NOT to participate

EMPLOYER USE
Employer must complete for mid-year enrollments
Date of first deduction:
Eligibility date:

DIRECT DEPOSIT

- I elect to participate (please do not fill out if you are already participating, unless you are changing accounts)
 checking account OR savings account



Financial Institution (name of bank): _____
Routing Number (always 9 digits): _____ Account Number: _____

If you would prefer, you can attach a voided check

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

TEAR ALONG THIS LINE