

# ENROLLMENT FORM CAFETERIA PLAN

**Employer:**

**Plan Year:**

(Please Print)

Name: \_\_\_\_\_ Social Security No. \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Email Address: \_\_\_\_\_

**NO**, I do not wish to enroll in the Cafeteria Plan (Plan). I understand that I cannot enroll at any other time during the Plan Year unless I experience a "Change in Status". I also understand that since I am not enrolling in the Plan, my premium contribution for medical and dental coverage will continue to be deducted from my pay on an after-tax basis.

**YES**, I elect to enroll in the Plan, effective \_\_\_\_\_, and authorize my employer to reduce my monthly pay and/or contribute to my account by the following amount(s):

	<u>Employee Contribution</u>	<u>Employer Contribution</u>
• My <b>monthly</b> premium for health insurance coverage (Group policies sponsored by your employer such as medical, vision or dental)	\$ ____/mo	\$ ____/mo
• My <b>monthly</b> allocation for supplemental insurance premiums (For certain policies not sponsored by your employer; i.e., AFLAC)	\$ ____/mo	\$ ____/mo
• My allocation <b>this plan year</b> for unreimbursed health expenses	\$ ____/yr	\$ ____/yr
• My allocation <b>this plan year</b> for dependent day care expenses (Annual maximum \$5,000 per family)	\$ ____/yr	\$ ____/yr

**I understand** that by electing to pay for my health insurance coverage through the Plan, my premiums will automatically be deducted from my pay on a before-tax basis. I authorize the employer to process these premium contributions as an automatic Plan reimbursement throughout the Plan Year.

**I understand** that the salary reduction I have elected for health expenses are recorded separately from the salary reduction for dependent day care costs or premiums. If there is money recorded in one account at the end of the year, it is not transferable to meet expenses in the other category.

**I understand** that I cannot suspend, increase or decrease my salary reductions during the Plan Year unless I experience a "Change in Status" as described in federal regulations.

**I understand** that all claims paid must be for services incurred during the current plan year as stated in the Plan Document.

**I understand** that any money remaining in my Cafeteria Plan Account at the end of the Plan Year will be forfeited by me. I have received a written explanation of the Cafeteria Plan Account. I understand that the employer cannot be responsible for any tax liabilities that may subsequently occur as a result of my Plan participation.

**I understand** that the MBI card must only be used for eligible expenses not being reimbursed by any other health plan, and I will save all card transaction information because my account may be audited at any time.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**This Plan Administered by Professional Benefit Services, Inc.**

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