PBS
Professional Benefit Services, Inc.

CAFETERIA PLAN ENROLLMENT FORM

Employer:	***Plan Year:***
Name:	***Employee ID: (last 4 SSN)***
Mailing Address:	***Phone Number:***
City: ***State:*** ***Zip:***	***Email Address:*** *Please provide an email address that is monitored regularly.*

☐**NO,** ***I do not wish to enroll in the Cafeteria Plan (Includes Pre-Tax Insurance Premiums, FSA or DCA withholdings).***
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 health insurance coverage will 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 pay by the following amount(s):***

1. "EMPLOYER SPONSORED" INSURANCE PREMIUMS

Monthly Salary Reduction for ALL insurance premiums (medical, dental, vision, etc.)	**$**

2. "INDIVIDUALLY OWNED" SUPPLEMENTAL INSURANCE PREMIUMS

**Cannot be an individually owned major medical policy, Medicare or COBRA premium. Call our office if you have questions on your plans eligibility.*

Monthly Salary Reduction for certain policies* (*not sponsored by your employer*)	**$**

3. FLEXIBLE SPENDING ACCOUNT ANNUAL ELECTION

**The federal maximum employee contribution to the health care account (FSA) is capped at a $2,550 annual election. Your specific plan may still have a lower maximum contribution.*
**HSA participants: If you are participating in an HSA (Health Savings Account), you cannot be a participant in a traditional FSA, the plan must offer a Limited Purpose FSA.*

Annual Salary Reduction for the flexible spending account (FSA)	**TOTAL ANNUAL FSA ELECTION**	**$**

4. DEPENDENT DAYCARE ACCOUNT ANNUAL ELECTION

**Please note- Dependent day care expenses include expenses incurred for the care of dependent children under the age of 13 so that you and your spouse can work, look for work or be a full-time student. School tuition may not be reimbursed. For handicapped dependents 13 and over, please contact Professional Benefit Services. The daycare election is capped at $5,000 per household.*

Annual Salary Reduction for the dependent daycare account (DCA)	**TOTAL ANNUAL DCA ELECTION**	**$**

☐**I understand** that by electing to pay for my health insurance coverage through the Cafeteria 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 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 date of services incurred during the current plan year as stated in the plan document.

☐**I understand** that if I have a benefits card, it 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.

☐**I understand** that any money remaining in my cafeteria plan account(s) at the end of the plan year may be forfeited. *Your plan may have optional plan features that can extend the plan year, or roll money over into the next plan year. These plan features are located in your summary plan description.

☐ I have received a written explanation of the cafeteria plan. I understand that the employer cannot be responsible for any tax liabilities that may subsequently occur as a result of my plan participation.

Your Signature:	Date:
Company Authorization:	Date:

An employee signature and company authorization is required for enrollment to be completed. Return completed form to your employer.

This Plan Administered by Professional Benefit Services, Inc.
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