

**The USI-125 Plan
A Section 125 Cafeteria Plan
Employee Enrollment Form**

Employer	Division/Dept	Hire Date	Employee #
Employee's Name (Last, First, Middle)		Social Security No.	
Street Address	City	State	Zip Code
Pay Period Effective Date	Number of Pay Periods	Pay Period (check one):	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Explain)

SALARY REDIRECTION FOR INSURANCE PREMIUMS

I understand that any premiums I am obligated to pay for health care coverage for myself and any of my dependents will be deducted from my pay on a BEFORE-TAX basis unless I otherwise direct.

FLEXIBLE SPENDING ACCOUNTS

Unreimbursed Medical Expense Flexible Spending Account (FSA)
(check one)

_____ I wish to redirect the following amounts to my Unreimbursed Medical Expense FSA. I understand this is in addition to the amount redirected for my premiums.

\$ _____ per pay period x _____ # of pay periods = \$ _____ Annual election

_____ I do not wish to redirect any additional money for eligible health care expenses.

If you are currently covered by American Medical Security for Medical and/or Dental coverage and wish to have your unpaid eligible Medical and/or Dental expenses automatically reimbursed from your Advantage Plan Flexible Spending Account, please check this box.

Dependent Care Expense Flexible Spending Account (FSA)
(check one)

_____ I wish to redirect the following amounts to my Dependent Care FSA. I understand this is in addition to the amounts which have been redirected above. I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, a lower maximum applies.

\$ _____ per pay period x _____ # of pay periods = \$ _____ Annual election

_____ I do not wish to redirect any additional money for eligible dependent care expenses.

I understand that the choices I have indicated above must remain in effect for the entire plan year unless I have a change in family status. A change in family status includes the birth or adoption of a child, marriage, divorce, death, spouse losing or gaining a job, or a change in employment status from part-time to full-time or full-time to part-time.

I understand that the IRS requires any funds remaining in a flexible spending account at the end of the Plan Year must be forfeited by me to be returned to my employer. I understand there is a sixty (60) day grace period after the Plan Year end in which to submit expenses as long as the expenses were incurred with the Plan Year.

The effective date of the Plan Year and the end of the Plan Year should be verified with your Employer, (the Plan Administrator).

_____ hereby give my employer permission to reduce my salary by the above elected amounts.

Signature: _____

Date: _____