

## Cafeteria Plan- Sec. 125 Enrollment Form

<b>NAME:</b>	Last	First	MI	<b>SS#:</b>	
<b>ADDRESS:</b>	Street	City	State	<b>PHONE:</b>	( ) ( )
<b>COMPANY:</b>	El Paso County			<b>FAX:</b>	( ) ( )

### EMPLOYEE BENEFIT OPTIONS

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction or after-tax deduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

<u>PREMIUM CONVERSION</u>	<u>REIMBURSEMENT ACCOUNTS</u>
<i>Salary Reduction per pay period</i>	<i>Salary Reduction per pay period</i>
Group Health Insurance.....\$ _____	FSA Medical Expenses.....\$ _____
Group Dental.....\$ _____	FSA Dependent Care.....\$ _____
Group Vision.....\$ _____	
<b><u>ANNUALIZED DEDUCTION TOTALS:</u></b>	<b><u>ANNUALIZED DEDUCTION TOTALS:</u></b>
Group Health Insurance.....\$ _____ per plan year	FSA Medical Expenses.....\$ _____ per plan year
Group Dental.....\$ _____ per plan year	FSA Dependent Care.....\$ _____ per plan year
Group Vision.....\$ _____ per plan year	
	<b><u>ANNUAL SALARY</u>.....\$ _____</b>
	<b><u>EFFECTIVE DATE</u>..... / /</b>
<b><u>PAY SCHEDULE:</u></b>	
Weekly ( )    Bi-Weekly ( )    Monthly ( )    Semi-Monthly ( )	

I hereby authorize to **ELECT ( )** **DECLINE ( )** participation and direct my employer to reduce my salary in the amount necessary to pay for the benefit coverages listed above and understand that this amount will not be subject to Social Security or Federal Income Tax withholding, which may result in a reduction of future Social Security benefits to which I may be entitled. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date the Plan. I further authorize future adjustments in the amount of the salary reduction in the event the cost of coverage in any program selected above under the heading PREMIUM CONVERSION is changed by the carrier during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed. I am aware that once I have elected to participate in this Plan that I may not revoke my election until the end of the Plan Year with the exception of a Change in Family Status. I understand that my unused balance of the reimbursement accounts, if any, at the end of the Plan Year will be forfeited by me back to my employer.

**This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as listed on the Status Change Matrix I received with the Summary Plan Description.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

ASSURES BENEFITS ADMINISTRATORS

4100 RIO BRAVO, SUITE 211

(915)532-2100 EXT 127 FAX (915)532-1339

<b>RECEIVED/PROCESSED BY:</b>	<b>FOR ABA'S USE ONLY:</b>	<b>DATE:</b>
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