



No Change Annual Benefit Plan Enrollment Form/Flex Enrollment and Beneficiary Change (see back)

Effective Date: July 1, 2011

HR USE ONLY:

Annual Salary: _____

- Annual Enrollment
Full-Time (40 + hours/week)
Part-Time (25 <32 hours/week)
Part-Time (20 <25hours/week)
Exempt Non-Exempt

INSTRUCTIONS:

- 1. Employee must complete all parts of this form.
2. Please print & complete in ink.
3. Form must be signed & dated for coverage to be effective.
4. You must initial where indicated when waiving coverage.

Social Security #: _____

Date of Birth: _____

Last Name: _____

First Name: _____ MI: _____

Address: _____

City, State, Zip: _____

Telephone: _____

- Sex: Male Female
Marital Status: Single Married Divorced

I want to continue my benefit elections as they are currently stated on my most recent enrollment form.

Sign Here to maintain all current Benefits: _____ Date: _____

Should I elect to make changes during the plan year I understand that if my medical and/or dental premiums are paid on a pre-tax basis, changes will be allowed only if I have a qualifying event such as: 1. Marriage; 2. Divorce or legal separation; 3. Death of a spouse or dependent; 4. Birth or adoption of a child; 5. Termination or commencement of spouse's employment; 6. A change in employment status of the employee or his/her spouse from part-time to full-time, or full-time to part-time; 7. The taking of an unpaid leave of absence by the employee or his/her spouse; 8. A significant change in the health coverage of the employee or his/her spouse's employment.

PART I- MEDICAL EXPENSE REIMBURSEMENT ACCOUNT - HEALTH PLANS INC. Pre-Tax

I elect to participate in Employer sponsored Medical Care Reimbursement Account Program.

I authorize \$_____ per pay period for a maximum of _____ pay periods to be used for Medical Care Reimbursement. Annual contribution \$_____

Maximum of \$ 2,000 annually; Minimum of \$240 annually (to be pro-rated based on date of hire)

I do not want to participate in the Medical Care Reimbursement Account Program _____ Initials

PART II- DEPENDENT CARE REIMBURSEMENT ACCOUNT - HEALTH PLANS INC. Pre-Tax

I elect to participate in Employer sponsored Dependent Care Reimbursement Account Program.

I authorize \$_____ per pay period for a maximum of _____ pay periods to be used for Dependent Care Reimbursement. Annual Contribution \$_____ Maximum of \$5,000 or \$2,500 if married filing separate returns

I do not want to participate in the Dependent Care Reimbursement Account Program _____ Initials

Flex Enrollment

SIGNATURE _____ DATE _____

***PLEASE DO NOT FORGET TO SIGN THIS FORM ***

BENEFICIARY CHANGE FORM
 (Change becomes effective date signed)

**Beneficiary Designation: All employees MUST designate a beneficiary. If more than one Beneficiary is named, indicate percentage.
 Applies to Supplemental Life**

Name of Beneficiary	Relationship	Social Security #	Date of Birth	Address	%
Primary					
Primary					
Secondary					
Secondary					

Signature: _____

Date: _____