Qualified Plan Services, Ltd.

"Our job is to make your job easier"

Flexible Spending Accounts (FSAs)
Dependent Care Reimbursement Accounts
Pre-tax Premium Payment Plan

Cafeteria 125 Plan
Enrollment Form

EMPLOYEE INFORMATION					
Your Employer		Your Name (Last, First, Middle)			SSN
Home Mailing Address		City	State	Zip	Email
Work Telephone	Home Telephone	Marital Status	Date of Birth	Date of Hire	Date of Eligibility
Dependent Names					

PRE-TAX REIMBURSEMENT ACCOUNT ELECTIONS		
# of Pay Periods/Year: ☐	**Flexible Spending Account** (Medical Reimbursement)	**Dependent Day Care Reimbursement** Maximum $5,000/yr. ($2,500/yr. if married filing separate tax returns)
Annual Election	**$**	**$**
Deduction Each Pay Period	**$**	**$**

Note: If you are making an election for the whole year, divide your annual election by the number of pay periods in the plan year. If you are making an election mid-year, divide your annual election by the number of **remaining** pay periods in the plan year.

PRE-TAX PREMIUM PAYMENT ELECTIONS			
Note: Enter your deduction each pay period below.	**Medical Insurance**	**Dental Insurance**	**Other (specify)**
Single	**$**	$	$
Employee & Spouse	**$**	$	$
Employee & Child	**$**	$	$
Family	**$**	$	$

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summary Plan Description and the Notice of HIPAA Privacy Practices.

Signature: ______________________________ Date: ________________