



Select Data Service Administrators, Inc.

P.O. Box 2076, Batesville, Arkansas 72503
 Phone: (888) 698-1429 FAX: (888) 877-4747

Employee Enrollment Form

INSTRUCTIONS: Please PRINT clearly and SUBMIT this form to Your Benefits Administrator.

View your account on-line at www.selectdataservice.com

SECTION I – PLAN ELECTION

1. Type of Product (s) <input type="checkbox"/> Health Care (FSA) <input type="checkbox"/> Dependent Care(FSA) <input type="checkbox"/> Third Party Insurance	Effective Date	Group #	Division #	Package
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SECTION II – PERSONAL INFORMATION

2. Employer Name		3. Full-Time Hire Date (Month / Day / Year)		
4. Employee Name (Last Name, First Name, Middle Initial)				
5. Social Security Number	6. Birth Date (Month/ Day/Year)	7. Marital Status (choose one) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced		
8. Employee Mailing Address (Street, City, State, Zip)				
9. E-Mail Address	10. Home Phone ()	11. Work Phone ()		

SECTION III – ELIGIBLE DEPENDENTS

12.A. Name (Last Name, First Name, Middle Initial)	SSN (Optional)	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
Choose One Relationship: 1) Spouse 2) Child/ Step Child 3) Other					
12.B. Name (Last Name, First Name, Middle Initial)	SSN (Optional)	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
Choose One Relationship: 1) Spouse 2) Child/ Step Child 3) Other					
12.C. Name (Last Name, First Name, Middle Initial)	SSN (Optional)	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
Choose One Relationship: 1) Spouse 2) Child/ Step Child 3) Other					
12.D. Name (Last Name, First Name, Middle Initial)	SSN (Optional)	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
Choose One Relationship: 1) Spouse 2) Child/ Step Child 3) Other					

* If you are enrolling with more than 4 dependents, please include another signed enrollment form or plain sheet of paper with the dependent information filled out as above.

SECTION IV – ELECTION AMOUNTS (continued on page 2)

HEALTH CARE / MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)		DEPENDENT CARE (Daycare) FLEXIBLE SPENDING ACCOUNT (FSA)	
13. You may elect any amount up to the annual maximum election set by your employer (please refer to your enrollment kit or ask your employer for the annual maximum amount). The annual maximum includes your employer contribution, if applicable. <input type="checkbox"/> I elect to contribute \$_____ for the plan year to a Health Care / Medical Flexible Spending Account (FSA) on a pre-tax basis. I understand that I will forfeit any amount remaining in this account after all eligible expenses are submitted for reimbursement, should I overestimate my annual needs. <input type="checkbox"/> I wish to have my employer's contribution applied to the Health Care FSA (If applicable).		14. You may elect any amount up to the annual maximum election of \$5,000 per family (if you are head of household or married and file a joint tax return) or \$2,500 (if you are married and file a separate tax return).* The annual maximum includes your employer contribution, if applicable. <input type="checkbox"/> I elect to contribute \$_____ for the plan year to a Dependent Care Flexible Spending Account on a pre-tax basis. I understand that I will forfeit any amount remaining in this account after all eligible expenses are submitted for reimbursement, should I overestimate my annual needs. <input type="checkbox"/> I wish to have my employer's contribution applied to the Dependent Care FSA (if applicable).	
Payroll Deduction Amount \$	First Payroll Deduction	Payroll Deduction Amount \$	First Payroll Deduction

* Special lower limits exist for spouses who are full-time students. Please contact your Benefits Administrator for guidance.

SECTION IV – ELECTION AMOUNTS (continued from page 1)

THIRD PARTY INSURANCE (Individual) PRE-TAX REIMBURSEMENT

16. You may elect any amount **up to the amount of your insurance premium.**

I elect to contribute \$ _____ for the plan year to a pre-tax basis for payment of third party insurance premiums. I understand that I will forfeit any amount remaining in this account after all eligible expenses are submitted for reimbursement, should I overestimate my annual needs.

Payroll Deduction Amount \$

First Payroll Deduction

Employee Payroll Frequency: Weekly Bi-weekly Semi-monthly Monthly Other _____

SECTION V – AUTHORIZATION / EMPLOYEE SIGNATURE (skip section VI)

I understand that:

- This election will remain in effect for the duration of the plan year.
- To participate in succeeding years, I must complete a new form.
- I cannot submit claims incurred prior to the date I joined or after the plan year ends
- My employer cannot be responsible for any tax liabilities, which I may incur as a result of my participation in the Plan.
- I cannot suspend, increase or decrease these deductions during the plan year unless I experience a valid change in status (See the below for a list of valid changes).

I authorize payroll deductions for the total amount(s) indicated into my selected Plan Accounts, and certify that I have read both sides of this enrollment form.

17. Employee Signature

18. Date

SECTION VI – BENEFIT REFUSAL (skip section V)

I do not wish to participate in the Flexible Spending Account, Third Party Insurance Pretax or the Health Reimbursement Arrangement program at this time. I understand that I may not elect to participate in the Plan until the next open enrollment period unless I have a valid change in status. (See below for a description of valid changes)

19. Employee Signature

20. Enroller Initials

21. Date

Valid changes in status for the health care and dependent care FSA accounts are:

- Legal marital status—marriage, divorce, death of spouse, legal separation, or annulment;
- Number of dependents—birth, adoption, placement for adoption or death of a dependent;
- Employment— change in employment status of employee, spouse or dependent to include termination or commencement of employment by; a strike, lockout, commencement or return from an unpaid leave of absence, change in work site, Switching from part-time to full-time (or vice-versa);
- Residence—a change in the residence of employee, spouse or dependent that changes the service area you are located in;
- Dependent Eligibility—Situations where a dependent satisfies or ceases to satisfy the rules for eligible dependents—due to the attainment of age, student status, or similar circumstances as provided in the plan;
- Adoption Assistance—commencement or termination of adoption proceedings;
- Certain Cost or Change in Coverage—changes in a spouse's benefit program. (Most cost/coverage changes merely allow adjustments in annual election amounts, but do not inherently constitute valid status changes.)

The above changes are defined by the Federal Government. Subsequent benefit-election changes must be based on then-current definitions; and increases or decreases in annual election amounts ordinarily must both be caused by and consistent with any change action. More information on them can be obtained from your benefits representative(s).