Vantage Flex LLC

SECTION 125
EMPLOYEE ENROLLMENT FORM

**** NOTE** Online enrollment with electronic signature is available. Call 800-871-9011 for details.**

Please Print

Company Name: Sawyer County Plan Year: 2016 Effective Date ___/___/_____

Last Name:_____ First Name:_____ Middle Init.:_____

Address : _____City:_____ State: _____ Zip:_____

Social Security #: _____-_____-_____ Date of Hire_____ Date of Birth_____

E-mail:_____ Phone: _____

Spouse: _____SS #: _____-_____-_____ Date of Birth ___/___/_____
Dependant: _____SS #: _____-_____-_____ Date of Birth ___/___/_____
Dependant: _____SS #: _____-_____-_____ Date of Birth ___/___/_____
Dependant: _____SS #: _____-_____-_____ Date of Birth ___/___/_____
Dependant: _____SS #: _____-_____-_____ Date of Birth ___/___/_____

With regard to my pay reductions under this agreement, I understand that:

- Expenses for reimbursement must be incurred **during** the plan year.
- If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my reduction will automatically be adjusted.
- I cannot change or revoke this pay reduction agreement at any time during the year unless I have a change in status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, HIPPA qualifying changes, termination or commencement of employment of my spouse's employment status.
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections. If I do not complete and return a new election form at that time, I will be treated as having elected to continue only my insured benefits then in effect for the new plan year.
- Dependent care reimbursement will be available only for qualifying dependent care expenses as described in the Internal Code Section 129, and I understand I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this program. I further acknowledge that the total election for me and my spouse cannot exceed the amount outlined in the employer plan document.

Elections

Check All That Apply	**Annual Elections**		**Pay Period Election**
☐ Dependent Care Account ($5000 Maximum)	$_____	÷ 26 pay periods =	$_____
☐ Unreimbursed Medical Expenses ($2550 Maximum)	$_____	÷ 26 pay periods =	$_____

☐ I acknowledge I have been informed of the terms of the flexible spending account options. Even though I am eligible to participate in the plan, I hereby elect not to enroll. This waiver will remain in effect for the remainder of this plan year; however, I may enroll this plan year if I have a change in status.

ELECTIONS MADE AT THE BEGINNING OF THE PLAN YEAR CANNOT BE CHANGED UNLESS YOU HAVE A CHANGE IN FAMILY STATUS.

I understand that by signing and submitting this form, I am making an irrevocable election for the Plan year indicated above.

Signature: _____Today's Date: _____