

Enrollment Form

Fax to:

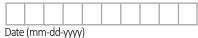
Mail to:

608 831 4790 Employee Benefits Corporation, PO Box 44347, Madison WI 53744-4347 800 346 2126 | 608 831 8445 Phone support: participantservices@ebcflex.com E-mail support:

Submit completed form to your Employer.

General Information											
General mormation											
Organization Name		Division									
Participant Information Please print.											
Last Name		Suffix	First Name						_	MI	
Participant Social Security or Identification Number Gende	M O F Date of Birt	h (mm-dd-yyyy)	Date of	of Hire (mr	I-dd-yyyy)					
Mailing Address	Apt. No.	City				State	Zip	Code			
Home Phone 123-456-7890	-mail Address (we do no	t share your e-ı	nail address)								
Plan Dates (refer to "My Company Plan" Eligibility sect Effective Start Date (mm-dd-yyyy) Number o Plan Benefits:	f Pay Periods	and placed into	the following ac	counts:							
	Employee per Pa	Election ay Period		Employee Elect Plan Year			Employ	er Contril	bution: Plan Ye	s (if any) ear Tota	
Health Care FSA Reimburses all eligible medical expenses; do not use with HSA	\$		\$			\$					
Dependent Care FSA Reimburses eligible child or elder care expenses (e.g., daycare)	\$		\$			\$					
Employee Paid Administrative Fees ^(if any)	\$		\$			\$					
Direct Deposit (optional; if you have not done so, cor	nplete banking informa	tion below to	oarticipate – aut	horization is ir	n effect fror	n plan year	to the n	ext)			
Financial Institution							Zip	Code		_	
Checking Savings Account Number	Number					Number (Number (exactly 9-digits)				
Authorization											
O I enroll in the BESTflex Plan	o enroll in the BESTflex P	lan									
agree this election cannot be revoked or changed during the pla stand my Social Security benefits may be affected by my participa f elected by the plan sponsor) cannot be returned to me (HSA co paychecks. If a debit card has been provided to me, I certify I will do nor will I seek reimbursement under another Plan. I agree to prov have been reimbursed in error for an expense ineligible under th	tion in this Plan and that a ntributions are exempt fro only use the Card for payr ide substantiation that ar	iny money I alloo om this rule). You nent of eligible e y expense is elig	ate to these acco ir annual election openses under th ble for reimburse	unts and do no will be rounde e Plan and any ment under th	ot spend by ed down if it expense pa ne Plan, and	the end of t is not evenl id with the to reimburs	he plan y y divisible Card will e the Pla	ear (or geby the not be r n in case	grace numb reimbu es who	period, per of ursed ere	

ommercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it.



Х