

SECTION 125 FLEXIBLE BENEFIT PLAN EMPLOYEE ENROLLMENT AUTHORIZATION FORM

***Required Information**

* Employer		Job Title		*Present Salary \$	
*Employee Last Name	* First	* Mid.	E Mail Address		Phone #
* Employee's Address: (<u>Reimbursement Checks are sent to this address</u>) Street			City		State Zip
* Social Security Number	Date of Birth		___ Male	___ Single ___ Divorced	Hire Date
____/____/____	____/____/____		___ Female	___ Married ___ Widowed	____/____/____
*Pay Date Cycle: <input type="checkbox"/> Weekly (52/yr) <input type="checkbox"/> Semi-Monthly (24/yr)					
<input type="checkbox"/> Bi-weekly (26/yr) <input type="checkbox"/> Monthly (12/yr) <input type="checkbox"/> Other					

AUTHORIZATION FOR COVERAGE AND PARTICIPATION

Effective Date: _____

I request the following amounts to be deducted from my salary **per pay period, Starting on:** _____

To participate in Day Care, both parents must be gainfully employed.

Health Insurance Premiums	\$ _____	Day Care Expenses	\$ _____ Per Pay Period = _____ Annual
Other Premium	\$ _____		\$5000.00 Maximum
Other Premium	\$ _____		
Other Premium	\$ _____	Medical Expenses	\$ _____ Per Pay Period = _____ Annual
HSA Bank Account Deduction	\$ _____		<i>Maximum may vary. Check with HR</i>
Administration Fees	\$ _____	LTD Limited Medical	\$ _____ Per Pay Period = _____ Annual

LTD is for HSA participants and is for Dental/Vision reimbursement expenses only.

Companies with Grace Period will apply expenses incurred during the first 2 & 1/2 months, to remaining balances from the previous plan year.

DIRECT DEPOSIT ELECTION AUTHORIZATION

I elect and direct All Valley Administrators LLC to initiate deposits and/or corrections to the financial institution listed below:

<p style="text-align: center;">Direct Deposit</p> <p>Reimbursements are electronically deposited into your bank account. A Copy of/or Voided Check Must be attached. Deposit slips are not accepted.</p>	<input type="checkbox"/> Begin deposits <input type="checkbox"/> Cancel deposits <input type="checkbox"/> Continue deposits using last years information	<input type="checkbox"/> Checking <input type="checkbox"/> Savings	Routing # _____ Account # _____ Bank Name _____
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- I understand electronic funds transfers (EFT) will be initiated on the normal payment cycle date.
- Deposits may take up to three (3) business days to appear in the designated account.
- NSF fees resulting from non-deposit of funds are the sole responsibility of the participant.
- Returned items due to incorrect banking information will be assessed a \$25.00 fee.
- All Valley Administrators, LLC reserves the right to reverse ACH Direct Deposit transactions as deemed necessary.
- EFT notices can be viewed in your personal account, on the All Valley Administrators website: allvalleyadmin.com

I certify the information above to be correct and true to the best of my knowledge. I authorize payroll deductions from my earnings for any contribution I am making toward the cost of any of the above. Applicable funds at the end of the plan year not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Section 125 Flexible Benefit Plan deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status as defined in the Plan Document.

X _____ **X** _____
Signature Date

DECLINATION OF COVERAGE AND PARTICIPATION

I have been given the opportunity to participate in the above Section 125 Flexible Benefit Plan and have elected not to do so. If I later wish to enroll in this Plan, I understand that my eligibility and effective date will be determined according to Plan Document provisions elected by my Employer.

Signature Date

Completed Enrollment Forms Must Be Returned To Your Human Resources or Office Manager
All Valley Administrators, LLC