SECTION 125 FLEXIBLE BENEFIT PLAN
EMPLOYEE ENROLLMENT AUTHORIZATION FORM

Employer		Job Title Key Employee		Present Salary $	
Employee Last Name First Mid.		Phone #		E Mail Address	
Employee's Address: (Reimbursement **Checks** are sent to this address) Street		City		State Zip	
Social Security Number ___ ___ ___ / ___ ___ / ___ ___ ___ ___	Date of Birth _____ /_____ / _____	___ Male ___ Female	___ Single ___ Divorced ___ Married ___ Widowed	Hire Date ___ / ___ /___	Hrs.Worked Weekly?
Are you paid: [ ] Weekly (52/yr) [ ] Bi-weekly (26/yr)		[ ] Semi-Monthly (24/yr) [ ] Other _____ [ ] Monthly (12/yr)			

AUTHORIZATION FOR COVERAGE AND PARTICIPATION

I request the following amounts to be deducted from my salary **per pay period**, as follows:

Health Insurance Premiums $_____

_____ Other Premium $_____

_____ Other Premium $_____

Administration Fees $_____

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

Day Care Expenses $_____Per Pay Period = _____ Annual
$5000.00 Maximum

Medical Expenses $_____ Per Pay Period = _____ Annual
Maximum may vary. Check with HR

HSA LTD Medical $_____ Per Pay Period = _____Annual
Dental/Vision only

****Companies with Extended 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:

Direct Deposit Reimbursements are electronically deposited into your bank account. **A Copy of/or Voided Check Must be attached.** Deposit slips are not accepted.	Begin deposits Cancel deposits	Checking Savings	**Routing #**_____ **Account #**_____ **Bank Name**_____

- I understand electronic funds transfers (EFT) will be initiated on the normal check run 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.

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