CAFETERIA PLAN ENROLLMENT FORM

EMPLOYER NAME:

PERSONAL INFORMATION

Last Name:

First Name:

Birth Date: - -

Date of Hire: - -

SSN: - -

Address: City: St: Zip:

Day Phone: - -

Email Address:

PARTICIPANT BENEFIT ELECTION

☒ **INSURANCE PREMIUMS**: I elect to have all eligible health, dental, and/or vision premiums paid on my behalf with pretax dollars. I understand that this election will continue each plan year unless revoked by me. ☐ Waive participation.

☐ **MEDICAL/DENTAL/VISION ACCOUNT** (See Payroll HR Department for SPD limits) **Annual Election**: $.

☐ ***DAYCARE ACCOUNT*** (Max annual amount is $2500 Single/$5,000 if married, filing jointly) **Annual Election:** $.

DIRECT DEPOSIT AUTHORIZATION

BANK NAME:

☐ Checking Account - **Attach voided check**

☐ Savings Account - **Attach deposit slip**

BANK ADDRESS:

Routing Number:

CITY: ST ZIP

Account Number:

By signing this agreement, I authorize Ben-X, LLC to initiate credit entries to the account indicated above for the purpose of reimbursements from my flexible spending account(s). I also authorize Ben-X, LLC to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Sign Here for Direct Deposit

Account Holder Signature ______________________ Date ______________

PARTICIPANT SIGNATURE

I authorize the appropriate payroll deductions for the Cafeteria Plan until changed by me in writing. I understand that my cost for insurance premiums may be changed automatically in the event that my cost for insurance changes. I will only use the Cafeteria Plan account(s) and debit card for eligible expenses under the Plan, and I will be responsible to pay for expenses not allowed by the Plan. I understand that if it is later determined that I and/or my Spouse or Dependent(s) received an overpayment or a payment was made in error, I will be required to refund the overpayment or erroneous reimbursement to the FSA Plan. If I do not refund the overpayment or erroneous payment, the FSA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from my pay. If I have terminated employment, a collection process may be enforced to make the plan whole.

Sign Here to Enroll

Employee Signature ______________________ Date ______________

Ben-X, LLC ▪ ▪ Website: www.MyBenX.com

Fax (801) 224-1903 ▪ Phone (801) 229-2369 ▪ Toll Free (888) 433-2369 ▪ Email: Enrollment@BenXco.com

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