eflexgroup.com, inc.

3001 W. Beltline Hwy, Ste 302 ◆ Madison, WI 53713
Phone: (608) 243.8277 ◆ Fax: (608) 245.9342

☐ Check here for Direct Deposit and fill out form on back of enrollment form.

*Please **PRINT** Clearly*

ENROLLMENT FORM

Employer	Dept. Name/Location/No	☐ 12 Month Plan Year ☐ Short Plan Year	No. Of Payroll Deductions From Effective Date to End of Plan Year ________
Employee's First / Middle / Last Name			Social Security Number
Employees Home Address / Street / City / State / Zip			Home Phone
Birth Date Mo | Day | Year	Sex M | F	☐ Single ☐ Married	Spouse's Name	Employment Date	Employer Plan Effective Date
Employee E-mail Address				(**Employer Complete**) Date of 1st Deduction	(**Employer Complete**) Employee Effective Date for Plan Mo | Day | Year

I request the following amounts to be deducted pretax:

A. Group Premiums

If you participate in your employer's insurance plan(s), your premiums will automatically be deducted pre-tax unless you notify your Human Resource Department.

Reimbursement Sections :

	PLAN YEAR TOTAL		# OF PAY CHECKS		$ PER PAY CHECK
B. HEALTH FSA:	____________	÷	______	=	___________
C. DEPENDENT FSA :	____________	÷	______	=	___________
D. INDIVIDUAL HEALTH POLICY:	____________	÷	______	=	___________
Administrative Fees (If Any):	____________	÷	______	=	___________
TOTALS:	____________	÷	______	=	___________

☐ ***No, I do not want to enroll in the reimbursement sections.***

If a change of status occurs, I may have the right to sign on the plan at that time if my employer's plan allows.

Signature: *x*____ Date:______________

YES, I want to enroll. The IRS regulation states four conditions. **1.)** Any expenses you incur must be within the plan year. **2.)** Any expenses you incur must not be covered by any other source such as insurance. **3.)** You must provide proper documentation in order to receive payment. **4.)** You cannot change or revoke your elections during the plan year unless there is a specific change of status and your employer allows such changes. Please see the Summary Plan Description

NOTE: Enrolling may have a minor effect on your social security benefits. Please seek appropriate advice.

Signature: *x*____ Date:______________

Direct Deposit Authorization Form

Employee Name:	Social Security #:
Telephone No:	Employer:
Address, City, State, Zip	
e-mail:	

I request my Section 125 reimbursement direct deposit be placed in the following account(s):			
Institution	**Bank ABA Number**	**Account Number**	**Type of Account**
	#	#	❑ Savings ❑ Checking

PLEASE PROVIDE A VOIDED CHECK FOR EACH CHECKING ACCOUNT LISTED ABOVE. WE WILL NOT PROCESS WITHOUT A VOIDED CHECK.

DO NOT USE A DEPOSIT SLIP, THE NUMBER COULD BE INVALID!

I authorize my Section 125 Health FSA, Dependent FSA or Individual Health Premium reimbursements to be sent to the financial institution named above to be deposited in the designated account.

In the event funds are deposited erroneously into my account, I authorize my Section 125 provider to debit my account(s) not to exceed the original amount of the credit.

I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

Employee Signature:	Date:

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