

**Complete this form and return it to your human resources representative**

**Employee Information**

Employer Name \_\_\_\_\_  
 Employee Name \_\_\_\_\_ Account Number / SSN \_\_\_\_\_  
 Street Address \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

**Do you want to know if CONEXIS received and processed your claim? Please provide your e-mail address:**

E-mail Address \_\_\_\_\_

**Elections** (Additional plan information can be found at [www.conexis.org](http://www.conexis.org))

**Premium Only Plan** (contact your administrator for a list of qualified pre-tax benefit plan options)

- I elect to participate – I have enrolled in qualified insurance coverage on a separate enrollment form. I have been provided with a schedule showing my portion of the premiums for such coverage. These premiums will be taken on a pre-tax basis.
- I have been given the opportunity to participate in the premium only plan and have elected not to participate. I have enrolled in a qualified insurance plan and I understand premiums for such coverage will be paid on an after-tax basis.

**Healthcare Flexible Spending Account** (contact your administrator for the maximum allowed contribution)

- I elect to participate \$\_\_\_\_\_ per pay period x \_\_\_\_\_ remaining pay periods = \$\_\_\_\_\_ Plan Year Total
- I elect to waive coverage

**Dependent Care Flexible Spending Account**

Annual maximum allowable is:

- \$5,000 if married filing jointly or single
- \$2,500 if married filing separately

- I elect to participate \$\_\_\_\_\_ per pay period x \_\_\_\_\_ remaining pay periods = \$\_\_\_\_\_ Plan Year Total
- I elect to waive coverage

**Employee Certification**

- I understand I may elect coverage under any or all of the above components.
- I understand completion of this form does not guarantee insurance coverage will be initiated and, in most cases, an application for insurance must also be completed.
- I understand the terms of eligibility of this plan do not override the terms of eligibility of each of the available benefit plan options.
- I understand my election is irrevocable for the plan year unless I have a change in status or other qualifying event as defined in the IRS regulations, and the requested change is on account of and consistent with the event.
- I understand any unused contributions will be forfeited to my employer at the end of the plan year.
- I understand participation in this plan reduces my social security withholdings and could reduce my social security benefits.
- I certify I have read and agree to the terms above.



Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

For Employer Use Only					
Company Name	Division	Effective Date	Pay Cycle	Entered in Payroll	Initial