

# Section 125 Employee Enrollment Form



Employer Name		Employer Group #																							
Employee Name		Social Security #																							
Employee Preferred Contact Phone #		Employee E-mail																							
Street Address	City	State	Zip Code <input type="checkbox"/> Check here if new																						
Mailing Address	City	State	Zip Code <input type="checkbox"/> Check here if new																						
Date of Birth	Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	Check One <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced Date Employed																						
Spouse Name (First, M.I.)	Date of Birth	I request that my salary be reduced as follows: <table style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th style="text-align: center;">Annually</th> <th style="text-align: center;">Monthly</th> </tr> </thead> <tbody> <tr> <td>Contribution for Medical Coverage</td> <td style="text-align: center;">\$ N/A</td> <td style="text-align: center;">\$ N/A</td> </tr> <tr> <td>Contribution for Dental Coverage</td> <td style="text-align: center;">\$ N/A</td> <td style="text-align: center;">\$ N/A</td> </tr> <tr> <td>Other Contributions (SPECIFY)</td> <td style="text-align: center;">\$ N/A</td> <td style="text-align: center;">\$ N/A</td> </tr> <tr> <td><b>FSA - Unreimbursed Healthcare Expenses</b></td> <td style="text-align: center;"><b>\$</b></td> <td style="text-align: center;"><b>\$</b></td> </tr> <tr> <td><b>DCA - Dependent Care Expenses</b></td> <td style="text-align: center;"><b>\$</b></td> <td style="text-align: center;"><b>\$</b></td> </tr> <tr> <td colspan="2"><b>Total Authorized Reductions</b></td> <td style="text-align: center;"><b>\$</b></td> <td style="text-align: center;"><b>\$</b></td> </tr> </tbody> </table>			Annually	Monthly	Contribution for Medical Coverage	\$ N/A	\$ N/A	Contribution for Dental Coverage	\$ N/A	\$ N/A	Other Contributions (SPECIFY)	\$ N/A	\$ N/A	<b>FSA - Unreimbursed Healthcare Expenses</b>	<b>\$</b>	<b>\$</b>	<b>DCA - Dependent Care Expenses</b>	<b>\$</b>	<b>\$</b>	<b>Total Authorized Reductions</b>		<b>\$</b>	<b>\$</b>
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**AUTHORIZATION:** I certify the above information to be correct and true to the best of my knowledge and that any children listed are dependents under Section 152 of the Internal Revenue Code. I understand that any amounts remaining in my account(s) not used for expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I also understand that the Flexible Spending reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status, significant change in cost or coverage of my health plan or my spouse's health plan or separation from service as prescribed by IRS rules. If a change in family status occurs, you have thirty-one (31) days from the occurrence to change or revoke your election. Furthermore, I hereby authorize my employer to transfer my required health benefits contribution on a monthly basis to the TML Health Benefits Pool. I agree to only submit claims which qualify as medical expenses under Section 213, Internal Revenue Code or dependent care expenses under Section 129, Internal Revenue Code.

<b>I ACCEPT:</b> <input type="checkbox"/> <b>FSA - Unreimbursed Healthcare Expenses</b> <input type="checkbox"/> <b>DCA - Dependent Care Expenses</b>
_____ Employee Signature <span style="float: right;">Date</span>

<input type="checkbox"/> <b>WAIVER OF PARTICIPATION:</b> The benefits of the plan have been thoroughly explained to me and I <b>decline</b> to participate.
_____ Employee Signature <span style="float: right;">Date</span>

**Please return this form to your employer.**

CONFIDENTIALITY NOTICE: The information contained in this transmission, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited by Federal law. If you are not the intended recipient of this message, you are notified that you may not disclose, print, copy or disseminate this information. If you have received this transmission in error, please reply to the sender and delete or destroy the message. Unauthorized interception of this transmission may be a violation of criminal law.