

**Employee Information** (please print clearly)

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Dept/Location \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Employee Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ email \_\_\_\_\_

Male  Female  Single  Married Spouse's Name \_\_\_\_\_

Employment Date \_\_\_\_\_ Plan Effective Date \_\_\_\_\_  
Month Day Year Month Day Year

**Employer Information** (Employer to complete the information below)

Date of 1<sup>st</sup> Payroll Deduction \_\_\_\_\_  12-Month Plan Year  
Month Day Year

Employee Plan Effective Date \_\_\_\_\_  Short Plan Year  
Month Day Year

**Employee Elections** (Employee/plan participant to complete the information below)

**A. Group Medical Premiums** – if you participate in your employer’s insurance plan(s), your premiums will automatically be deducted on a pre-tax basis unless you notify your Human Resource or Personnel Department.

	Annual Election	# of Payroll Deductions	\$ Per Pay Check
B. Health FSA	\$ _____ / _____	=	\$ _____
C. Dependent Daycare FSA	\$ _____ / _____	=	\$ _____
D. Individual Health Policy	\$ _____ / _____	=	\$ _____
E. Administration Fee (if any)	\$ _____ / _____	=	\$ _____
<b>TOTALS</b>	\$ _____ / _____	=	\$ _____

- No, I do not want to enroll.** If a change in status occurs, I may have the right to enroll in the plan at that time (if my employer’s plan allows).
- Yes, I want to enroll.** The IRS regulations state four conditions. 1) Any expense 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 to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes. Please see the Summary Plan Description for details.

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

**Direct Deposit Information**

**Employee Information**

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Alternate Telephone (work/cell): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

**Bank Account Information**

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

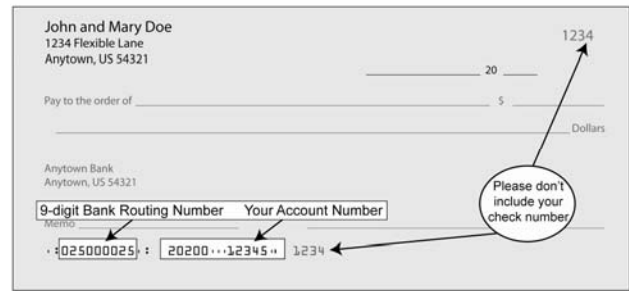
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name on the Account: \_\_\_\_\_

Routing and Transit Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

**IMPORTANT:** Please provide a voided check for each account listed above. We will not process without a voided check. Do not use a deposit slip as the number could be invalid.



**Authorization**

I authorize reimbursements from my Section 125 Health FSA, Dependent FSA, Individual Health Premium, or my Section 105 Health Reimbursement Arrangement 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 125/105 administrator 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please fax, email, or mail completed form with a voided check to:**

Toll Free Fax: 1.877.231.1287 • efgsales@eflexgroup.com  
eflexgroup.com • 2740 Ski Lane • Madison, WI 53713