



Flexible Benefit Plan Enrollment Form

Please Print

Employee Name _____	Social Security # _____ - _____ - _____
Home Address _____	
City _____	State _____ Zip _____
Daytime Telephone _____	Email _____
Employer Name _____	Branch/Location _____
Benefit Plan Year: ____/____/____ to ____/____/____ Number of Payroll Deductions: _____	
Date of First Deduction: ____/____/____ Effective Date: ____/____/____	

Limited Purpose FSA (LPFSA) (to be used if you participate in an HSA)

I elect \$ _____ x _____ = \$ _____ for reimbursable dental/vision expenses for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

Dependent Care FSA (DCFSA)

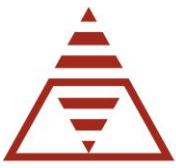
I elect \$ _____ x _____ = \$ _____ for reimbursable dependent care expenses for the above plan year.
(per payroll deduction) (# of payroll deductions) (total election)

Waiver

I do not want to participate in the Flexible Benefit Plan (areas listed above). My employer has offered me the opportunity to enroll and I am declining to participate for the above plan year.

I understand that my employer will deduct my election in equal amounts from my paycheck throughout the plan year. If at the end of the plan year the total declared reduction in my compensation exceeds the substantiated expenses, I understand that unused funds may become the property of my employer depending on the provisions of the plan. I also understand that I will have an opportunity to make a new election, if I so desire, prior to the beginning of each subsequent plan year, in accordance with the procedures described in the Plan Document. By affixing my signature below, I certify that I have examined this Agreement and understand and agree to comply with the terms of the plan and applicable code sections of the Flexible Benefit Plan. All amounts listed will be incurred (meaning having a date of service) within the Flexible Benefit Plan Year. I also understand that Diversified Benefit Services, Inc. is not engaged in giving tax or legal advice and that I have consulted with my tax accountant on the appropriateness of the plan for me. I also understand that my monthly Social Security retirement benefit, if I receive one, may be reduced slightly by contributing pre-tax dollars to a Flexible Benefit Plan. Also, by providing an electronic mail address (email), consent is given to receive unencrypted information regarding my FSA reimbursement account, including claims and personal health information, in electronic form at the e-mail address provided.

Employee Signature _____ Date _____



Excellence in Benefit Management Solutions

Participant Information (please print):

Employer Name: _____

Participant Name: _____ Last Four Digits of SS#:

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Participant Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

Check Box for New Account/Change/Cancel (please select one):

New Account Change Account Cancel Direct Deposit

Check the Plan that you will Participate in for Direct Deposit (please select all that apply):

Section 105 Health Reimbursement Arrangement Section 125 Flexible Spending Account

Participant Banking Information:

I would like my reimbursements to be deposited to the account listed below:

Financial Institution: _____

Routing # (nine digits): _____ (is usually between the **⌚** symbols on your check)

Account #: _____ (is usually between the **||** symbols on your check)

Account Type:

- Checking (attach a voided or cancelled check)
- Savings (Please DO NOT attach a deposit slip. Most deposit slips have the bank's *internal* routing number. Please obtain the proper routing number from your financial institution.)

Please Read the Terms and Sign Below

I hereby authorize Diversified Benefit Services, Inc. (DBS) to reimburse amounts owed to me by initiating credit entries to my account at the financial institution listed above. Additionally, I hereby authorize the financial institution to accept and to credit any credit entries initiated by DBS to my account. I acknowledge and agree that in the event DBS deposits or credits funds incorrectly to my account, and/or in the case of an overpayment (fraudulent, inadvertent, or otherwise), I authorize my employer to debit my account for an amount not to exceed the original amount of the incorrect credit. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor. I understand that DBS is responsible for the successful transaction of funds into my account. I agree to hold DBS harmless from loss and to indemnify DBS, limited to the amount of the deposit.

Any dispute arising out of or in connection with this agreement, if not resolved through other methods, shall be determined in accordance with the laws of the State of Wisconsin.

This authorization is to remain in full force and effect until my employer and financial institution have received written notice from me of its termination. The written notice shall be delivered in such a manner as to afford my employer and financial institution reasonable time to implement the change.

Participant Signature: _____ **Date:** _____

Diversified Benefit Services, Inc.
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Hartland, WI 53029
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Fax (262) 367-5938
DBSbenefits.com