

CUSTOM BENEFIT ADMINISTRATORS
PREMIUM, HEALTH CARE REIMBURSEMENT AND
DEPENDENT CARE REIMBURSEMENT ENROLLMENT FORM

Instructions: Complete the sections below, sign and date the form. Return the completed form to your employer.

New Plan Year Election (Complete Sections I, II, and III) **Plan Year:** _____ **Eff. Date:** _____

Section I – Employee Information (Please Print)

Social Security Number	Company Name	Married?	# of Dependent Children
Participant Name (Last, First, MI)		Date of Birth	E-mail Address
Home Address		Hire Date	Work Phone
City, State, Zip Code			Home Phone

Section II – Account Elections (Please Complete items 1, 2, and 3)

1. **Pre-Tax Premium Election:** I elect to have my required employee contributions withheld on a pre-tax basis for these coverages:
 (Check the box for the coverage premium(s) you are electing)

<input type="checkbox"/> I wish to have my medical premiums take out pre-tax:	<input type="checkbox"/> Single	<input type="checkbox"/> Family
<input type="checkbox"/> I wish to have my dental premiums taken out pre-tax:	<input type="checkbox"/> Single	<input type="checkbox"/> Family
<input type="checkbox"/> I wish to have my life premiums taken out pre-tax.		
<input type="checkbox"/> I do not wish to make a pre-tax premium election.		

2. **Health Care Reimbursement:**

I wish to participate in the health care reimbursement account option.

I elect \$ _____ as my total to be contributed
 on a pre-tax basis to my Health Care Reimbursement Account.

Per Pay Period
 Per Plan Year

I do not wish to participate in the health care reimbursement account option.

3. **Dependent Care Reimbursement:** If electing to take Dependent Care Reimbursement, please fill out the Dependent Care Certification Statement on the back of this form.

I wish to participate in the dependent care reimbursement account option.

I elect \$ _____ as my total to be contributed
 on a pre-tax basis to my Dependent Care Reimbursement Account.

Per Pay Period
 Per Plan Year

I do not wish to participate in the dependent care reimbursement account option.

Section III – Signature

I hereby authorize my employer to deduct from my pay on a pre-tax basis the amounts elected above for the Plan Year. I understand that the payroll deducted amount will be available for the reimbursement of my qualifying expenses under the applicable benefit election incurred during the Plan Year and/or for the payment of my premiums in accordance with the terms of the formal Plan Documents while I am a Participating Employee. I further understand that my election is irrevocable until the first day of the next Plan Year. The only exception is for a status change under the terms of the Plan, which would allow me to make a new election for the remainder of the Plan year that is consistent with the status change. Any amounts left in a reimbursement account after all eligible reimbursements have been made will be forfeited.

Employee Signature _____ **Date** _____

Custom Benefit Administrators
 P.O. Box 1385
 La Crosse, WI 54602-1385

If you have any questions, please call:
 1-800-944-2188