SELF INSURED PLANS LLC

1016 Collier Center Way, Suite 200
Naples, Florida 34110
800-720-1774 • 239-403-7884 • Fax 239-403-9028

Flexible Compensation Program

Employee Enrollment Form

Employer	Division	Effective Date

EMPLOYEE'S NAME (Last, First, Middle)	Social Security Number
	- -

Occupation	Hours Regularly Worked Each Week For This Employer.	Date Employed: Month, Day, Year

Street Address	City	State	Zip Code

Date of Birth: Month, Day, Year	Check One:	Check One:	Dependent Health Coverage:
	☐ Male ☐ Female	☐ Married ☐ Widowed ☐ Single ☐ Divorced	☐ Yes ☐ No

Name	Date of Birth: Month, Day, Year
Spouse's Name (First M. Last)	
Dependent Name (First M. Last)	
Dependent Name (First M. Last)	
Dependent Name (First M. Last)	

I request that my salary be reduced PER PAY PERIOD as follows:

Medical and/or Life / Disability } Premium $ ______________

Unreimbursed Medical Espenses $ ______________

Child/Dependent Care Expenses $ ______________

Pay Cycles:
☐ Weekly ☐ Bi-weekly
☐ Semi-monthly ☐ Monthly

TOTAL AUTHORIZED REDUCTIONS $ ______________

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge and that the children listed under "Dependent Coverage" either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment.

Signature ______________________________ Date ______________

IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline to participate.

Signature ______________________________ Date ______________

Please return the original, signed form to your Administrator. Make and keep a photocopy for your records.