

## Self Insured Plans: EMPLOYEE ENROLLMENT FORM

Self Insured Plans LLC  
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 Naples FL 34110  
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yes _____	no _____	HRA
yes _____	no _____	RX
yes _____	no _____	Flexible Spending

**Medical Carrier:**  
**Opt out?**

New Enrollment	
Renewal	
COBRA	
Changes	

*Special Instructions:*

**Monthly HRA Amt.**

RX: Annual Deductible \$ \_\_\_\_\_

Co-Payments: \$ \_\_\_\_\_ \$ \_\_\_\_\_

EMPLOYER:	DIVISION	EFFECTIVE DATE
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Employee's Name	Date of Birth	SS#
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Address	City	State
		Zip:

Marital Status    Single    Married    Divorced    Widowed    Other:

Dependants:	Add/Delete/Change	Date of Birth	Social Security Number
Spouse:			
Child			
Child			
Child			
Child			

**To be filled out for Flexible Spending Only**  
*I request that my salary be reduced for pre taxed benefits as follows:*

	Amount
<b>Pre-tax Prem:</b> Medical Premium	\$ _____
Dental Premium	\$ _____
1.5% Health Insurance	\$ _____
Voluntary Benefits- List program below	\$ _____
<b>FLEX:</b> Unreimbursed Medical Expenses	\$ _____
Dependent/Childcare Expenses	\$ _____
<b>TOTAL AUTHORIZED DEDUCTIONS</b>	<b>\$ _____</b>

**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" reside with me in a parent-child relationship or are legally dependent on me for support. I understand that any remaining amounts remaining in my flex plan which are not used are forfeited in accordance with the plan provisions and tax laws. I further understand the flex plan will be in effect for the plan year and cannot be revoked unless there is a legal qualifying event.

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

**IF YOU DECLINE PARTICIPATION IN THE FLEXIBLE SPENDING, HEALTH RESERVE ACCOUNT, PREMIUM PRE-TAX, (PLEASE CIRCLE)**

Signature \_\_\_\_\_