



200 W. BROADWAY
MISSOULA, MT 59802
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FLEXIBLE BENEFITS ENROLLMENT FORM

EMPLOYEE:		CALENDAR YEAR:	
ADDRESS:		<input type="checkbox"/> NEW ELECTION	
CITY/STATE/ZIP:		<input type="checkbox"/> ELECTION CHANGE-SPECIFY EVENT AND DATE	
DEPARTMENT:		<input type="checkbox"/> MARRIAGE <input type="checkbox"/> BIRTH/ADOPTION	
HIRE DATE: DATE OF BIRTH:		<input type="checkbox"/> DIVORCE <input type="checkbox"/> DEATH	
<input type="checkbox"/> SSN: Gender/Pronoun:		<input type="checkbox"/> STATUS CHANGE-SPECIFY	
		<input type="checkbox"/> OTHER-SPECIFY	

FLEXIBLE BENEFITS ELECTION AUTHORIZATION

I request participation in the Flexible Benefits Program of the above named employer and authorize the deduction of a portion of my compensation to purchase the benefits listed below under IRC SEC. 125, "Before" or "After -Tax" as indicated.

MEDICAL SPENDING ACCOUNT	DEPENDENT CARE ACCOUNT
<i>ELECTION MUST BE FOR QUALIFIED EXPENSES WHICH COVER ONLY MYSELF, MY TAX DEPENDENTS AND/OR MY SPOUSE (IF FILING JOINTLY).</i> ANNUAL AMOUNT ELECTED: (For medical, dental & vision expenses) \$ _____ (Total amount for year) "BEFORE-TAX" CONTRIBUTION: \$ _____ Each Pay period	<i>CANNOT EXCEED THE LOWER OF HUSBAND'S OR WIFE'S ADJUSTED INCOME. NOTE: IF ONE SPOUSE IS A FULL-TIME STUDENT, PLEASE INQUIRE ABOUT LIMITATIONS.</i> ANNUAL AMOUNT ELECTED: (For qualified child, elder, handicapped care expenses) \$ _____ (Total amount for year) "BEFORE-TAX" CONTRIBUTION: \$ _____ Each Pay period

^{nl} PAYROLL DEDUCTED PREMIUM BENEFITS elected under IRC Sec. 125. Payroll-deducted premiums will be deducted on a "Pre-tax" basis for the current and **all subsequent plan years** based upon this election form until a signed election revocation is provided by the participant. (**ONLY NEED TO MAKE ELECTION ONCE – NOT EVERY YEAR**)

HEALTH INSURANCE PREMIUM <input type="checkbox"/> YES <input type="checkbox"/> NO	DENTAL INSURANCE PREMIUM <input type="checkbox"/> YES <input type="checkbox"/> NO	OPTICAL INSURANCE PREMIUM <input type="checkbox"/> YES <input type="checkbox"/> NO
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CERTIFICATION (Please read before signing). I CERTIFY THAT THESE ARE MY BENEFIT ELECTIONS AND THAT:

1. The dependents on whom I will be claiming medical or dependent care expenses either reside with me in a parent-child relationship or are legally dependent on me for support.
2. I am aware that premium and other contributions made under this plan are the property of my employer and will be used to purchase the elected coverage and cannot be refunded.
3. Reimbursement account claims must be accompanied by documentation of the out-of-pocket expense.
4. I understand that coverage applies only to expenses incurred during participation.
5. I understand that this agreement cannot be changed during the plan year unless I experience a qualified change in status.
6. This agreement cannot be revoked during the plan year.

Signed: _____ Date: _____

Human Resources Office Authorization: _____ Date: _____

DECLINATION OF PARTICIPATION: (Sign here only if you are not enrolling in the flexible benefits plan)

My employer's Flexible Benefits Program has been explained to me. I have been given the opportunity to participate and have elected not to do so.

Signed: _____ Date: _____