



Employee Enrollment / Change Form

Plan Year: _____

New Enrollment _____ (Must be received 2 weeks prior to plan effective date)

Change Data _____

Employee Information

Company: _____

Employee: _____
Last First

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ - _____ - _____ Date of Birth: _____
MM/DD/YY

Employee Email Address: _____

Dependants:

Dependent 1: _____
Last First

Relationship: _____ SS#: _____ - _____ - _____

Dependent 2: _____
Last First

Relationship: _____ SS#: _____ - _____ - _____

Dependent 3: _____
Last First

Relationship: _____ SS#: _____ - _____ - _____

Dependent 4: _____
Last First

Relationship: _____ SS#: _____ - _____ - _____

Dependent 5: _____
Last First

Relationship: _____ SS#: _____ - _____ - _____

Benefit Elections:

EE Medical Premium	Decline _____	Accepted _____	Per Pay Amount _____
EE Dental Premium	Decline _____	Accepted _____	Per Pay Amount _____
EE Other Premiums	Decline _____	Accepted _____	Per Pay Amount _____

Description: _____

EE Medical Reimbursement	Decline _____	Accepted _____	Per Pay Amount _____*
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(*Note subject to plan min/max)

EE Dependent Reimbursement	Decline _____	Accepted _____	Per Pay Amount _____*
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(*Note subject to plan min/max)

Total EE Per Pay Amount _____

Banking Information

Name of Institution: _____ Account Type: Savings ___ Checking ___

Routing #: _____ Account #: _____

Banking Authorization & Agreement

I (we) hereby authorize and request the COMPANY, to make payment of any amounts owing to me (either of us) by initiating credit entries to my (our) account indicated below in the bank named below, hereinafter called BANK, and I (we) authorize and request BANK to accept any credit entries initiated by COMPANY to such account and to credit the same to such account without responsibility for the correctness thereof.

I (we) authorize and request COMPANY to effect repayment to COMPANY for amounts owed it because of a prior erroneous credit initiated to my (our) account if prior to the correcting entry, the COMPANY has sent or delivered to me written notice of the correction and the reason therefore; and the correcting entry is transmitted in such time as to be delivered or made available to BANK before midnight of the tenth day next following settlement for the erroneous entry.

It is understood that this agreement may be terminated by me (either of us) at any time by written notification to COMPANY or BANK. Any such notification to COMPANY shall be effective only with respect to entries initiated by COMPANY after receipt of such notification and a reasonable opportunity to act on it. Any such notification to BANK shall be effective only with respect to entries credited to my (our) account by BANK after receipt of such notification and a reasonable time to act on it.

I (we) recognize, acknowledge and accept this service is being provided for my (our) convenience. As such, I (we) agree to hold the COMPANY, PayData Payroll Services, Inc., each participating bank and NACHA harmless from any claim incident to the operation of this plan, arising from any act or omission by the COMPANY and/or PayData Payroll Services, Inc. and their employees, including without limitation any claim based on alleged loss as a result of non-credit of any deposit, and any claim which may be made by any depositor as a result of the rejection of any of his/her debits because of insufficient funds arising from the failure to credit deposits to his/her account.

I have read the information describing the Medical Plan and agree to abide by the terms of the Plan Document. I recognize I must submit signed documents and a Reimbursement Request Form to the Plan's Administrator of the reimbursement of qualified expenses, as determined by the Internal Revenue Code. I further recognize that any unused amounts remaining in my Account after the close of a Plan Year will be forfeited. I understand that I will have a specified time period (determined by the Company) in which to submit qualified expenses following the close of a Plan Year or upon termination of participation. This time period will be communicated to me by the Company.

I hereby apply for the options listed above. I authorize COMPANY to adjust my pay as required by my election. I understand that the benefit options I have selected will remain in force throughout the plan year, unless I have a change in family status. A change in family status includes marriage, divorce, death of a spouse, or dependent, birth or adoption of a child, or a change in my spouse's employment.

Employee Signature: _____ Date: _____