



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



Medical Spending Account Reimbursement Claim Form

Company: _____

Employee: _____
Last First

Address: _____

City: _____ State: _____ Zip: _____

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

Employee Email Address: _____

Instructions

1. For medical/dental expense claims that were submitted to a medical plan or an insurance company but not paid by the carrier, attach copies of other insurance carrier claim and/or payment forms (explanation of benefits forms) to establish amounts not covered under the medical/dental plan.
2. For all other reimbursable expenses, copies of all bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Cancelled checks are not acceptable receipts.
3. Submit this form to PayData Flex (Fax: 802-338-5514). Please retain a copy for your records.

Expenses

Expenses (list below)

Item	Date of Expense	Reason for Payment**	Amount Paid
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

**Use the following letter designation for "Reasons for Payment":

- A. medical/dental expense submitted to insurance company but not paid by the carrier (for example; a co-insurance or deductible amount);
- B. medical/dental expense not covered by a benefit plan;
- C. optical expenses.

Employee Certification

I certify that all items requested to be reimbursed comply with COMPANY'S Flex Spending Account Program and such items have not and will not be covered by any other plan or program of any employer or other person. COMPANY does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature

Date



Dependent Care Reimbursement Claim Form

Company: _____

Employee: _____
Last First

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

Employee Email Address: _____

Dependent Name(s): _____

Day Care Provider: _____ SS#: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Dates of Services: _____ Through: _____

Charge for Service: _____ Per Hr. _____ Per Day _____ Per Week _____

Total Charges: _____

(Day Care Provider Signature or
attach copy of provider receipt)

Employee Certification

I hereby certify that all items requested to be reimbursed comply with the Company's Flexible Spending Account and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The Company does not accept responsibility for direct payments to any individuals other than the employee.

Employee Signature

Date