GROUP INSURANCE SERVICE CENTER, INC.
P.O. Box 9120
Marshfield, MA 02050-9120
(781) 829-8595

FLEXIBLE BENEFIT ENROLLMENT FORM

Employer	Division	Date of Birth	Mo.	Day	Yr.

Employee's Last Name	First Name	Mid. Int.	Date of Employment			

Employee's Home Address	(Street)	(City)	(State)	(Zip)	Effective Date of Coverage			

Marital Status	Social Security No.	Sex	Telephone
☐ Single ☐ Married ☐ Divorced ☐ Widowed		☐ Male ☐ Female	( )

List all Eligible Dependents (FIRST & LAST Name):

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

Check box if you are currently paying premiums to your employer for health coverage and now want them paid before tax: ☐

Unreimbursed Medical Expense Account Deductions $_____ ☐

Dependent Care Expense Account Deductions $_____ ☐

Other Pre-Tax Premiums (life, disability, etc.) $_____ ☐

Other After-Tax Premiums $_____ ☐

I understand that these funds will be accounted for separately and cannot be used interchangeably. ☐

AUTHORIZATION I certify the above information to be correct and true to the best of my knowledge and that the children on whom I will be claiming dependent expenses or child care, 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 deduction(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_____

DECLINATION OF PARTICIPATION I have been given the opportunity to participate in the above plan and have elected not to do so. I understand that I will not be given another opportunity to sign up until the next plan anniversary date.

Signature_____ Date_____

Information Supplied By Employer:

Salary: $_____ per _____

Frequency of Pay: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Highly Compensated: ☐ Yes ☐ No First Pay Date of Deduction: _____

Premium Paid for Health Care: $_____ per _____