

Section 125 Pre-Tax Enrollment Form

Employee Information

Employee Name

Employee ID

Department

Date of Birth

Social Security Number

Address

Phone Number

Email

Enrollment Election

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Enroll

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Change

Benefit Selections

Health Insurance

Dental Insurance

Vision Insurance

Flexible Spending Account (FSA) Annual Amount

Dependent Care FSA Annual Amount

Dependent Information

Name

DOB

Relationship

Authorization & Signature

I authorize my employer to reduce my salary by the amount necessary for the benefits I have selected.

Employee Signature

Date