ENROLLMENT FORM

EMPLOYEE NAME _____ **SOC. SEC.#** _____
Last First Middle (Last 4 digits)

ADDRESS _____
Street City State Zip Code

EMPLOYER NAME COUNTY OF JACKSON

FOR PLAN YEAR BEGINNING _____ **AND ENDING** _____

1st DEDUCTION DATE _____ **BIRTHDATE** ____/____/____ **HIRE DATE** _____

I request the following and/or amounts to be deducted Pre-Tax:

Premiums (As applicable)

Group Health Premium Yes_____

Group Dental Premium Yes_____

Flexible Spending Accounts	**Deduction per pay period**	**Annual Election (Total of 24 Pay Periods)**
Unreimbursed Medical	$ _____	$ _____
Dependent Care Expenses	$ _____	$ _____

Authorization: I certify the above information to be correct and true to the best of my knowledge and that the individual(s) 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 the Flexible Benefit deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or change employment status. I further 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 AM AWARE THAT A NEW ENROLLMENT FORM MUST BE SIGNED AND SUBMITTED EACH YEAR PRIOR TO DECEMBER 15TH EVEN IF THERE ARE NO CHANGES TO THE ELECTED AMOUNTS. (IF YOU ELECT PREMIUM ONLY PRETAX, IT IS NOT NECESSARY TO FILL OUT A NEW ENROLLMENT FORM EACH YEAR).

_____ _____
SIGNATURE DATE

DECLINATION OF PARTICIPATION: I have been given the opportunity to participate in the above plan and have elected not to do so.

_____ _____
SIGNATURE DATE