

My Personal Information:

First Name ^	Middle Initial	Last Name	
Home Address	City	State	Zip
Home Phone	E-mail Address (We do not share your e-mail address)	Social Security Number	
Birth Date Mo Day Year	Gender M F	Marital Status S M	Spouse's Name
Employer	Department Name/Location/No. (if applicable)	Date Hired	

Enrollment Form

My Plan Dates (Refer to "My Company Plan" Eligibility section)

My Effective Start Date	My Plan Year	Number Of Payroll Deductions From My Effective Start Date To End Of Plan Year
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My BESTflexSM Plan Benefits

Group Insurance Premiums

If you participate in your employer's insurance plan(s), your premiums will be automatically deducted from your pay before taxes unless you notify your employer otherwise.

My BESTflex Plan Accounts

Your annual amount will be rounded down if it isn't evenly divisible by the number of paychecks.
(\$1000 ÷ 50 = \$20.00: no rounding down; \$1000 ÷ 52 = \$19.23: rounded down to the nearest penny)

	Plan Year Total	No. of Paychecks	Deduction per Paycheck
I request the following amounts to be deducted, pre-tax:			
Health Care FSA	_____ ÷ _____	_____ = _____	
Dependent Care FSA (Maximum contribution: \$ 5000.00)	_____ ÷ _____	_____ = _____	
Employee Paid Administrative Fees (if any)	_____ ÷ _____	_____ = _____	
Totals:	_____ ÷ _____	_____ = _____	

Yes, I want to save tax dollars!

I agree this election cannot be revoked or changed during the plan year, unless there is a qualifying event that justifies the revocation or change as authorized by the IRC and Regulations. I understand that my Social Security benefits may be affected by my participation in this plan and that any money I allocate to these accounts and do not spend by the end of the plan year cannot be returned to me. I also understand that, to provide services to my employer in connection with one or more employee benefit plans maintained by my employer, EBC may need "protected health information" regarding coverage or benefits for me or my dependents under the plan. By signing this enrollment form, I hereby acknowledge EBC will obtain and use such information and disclose it to my employer (or to an insurer or other provider of services to the plan), but only for purposes of the plan and only for as long as EBC is providing services regarding the plan. Any information disclosed pursuant to this enrollment form will not be subject to redisclosure by the recipient, except for purposes of the plan. I understand that my enrollment can be denied if I do not sign this form.

Signature	Date
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No, I do not want to participate.

I understand that I have been given the opportunity to enroll in the BESTflex Plan with my employer on this date. I have elected not to do so in this plan year. I also understand that if there is a qualifying event, I may have a right to sign on to the plan at that time.

Signature	Date
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Copies: White: EBC, Yellow: Business, Pink: Employee