



SECTION 125 ENROLLMENT FORM

MICHIGAN EMPLOYEE BENEFIT SERVICES, INC. - 3809 Lake Eastbrook Blvd. - Grand Rapids, MI 49546
(616) 458-6327 - FAX (616) 458-3495- (800) 968-9682

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|--------------------------|--|--|--|---------------------------------|--|
| BASIC INFORMATION | Jackson County ISD | | | Social Security Number _____ | |
| | Employee Name _____ Last First Middle Initial | | | Date of Birth ____/____/____ | |
| | Home Address _____ Street City State ZIP | | | | |
| | Home Phone Number (____) _____ | | | Sex _____ Marital Status _____ | |
| | Date of Hire ____/____/____ | | | Job Title _____ Salary \$ _____ | |

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|-------------------|------|---------------|------------------------|-----|--------------------------|----------------------|
| DEPENDENTS | Name | Date of Birth | Social Security Number | Sex | Relationship To Employee | Dependent's Employer |
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READ CAREFULLY BEFORE MAKING YOUR ELECTION

- The salary conversion will be considered an Employer contribution to a Dependent Care Assistance Account, Medical Care Reimbursement Account, or Premium Conversion Account, as the case may be, which may be used to pay the specified expenses of the Employee as described in this plan.
- Any balance in the Employee's Account(s) *will no longer be usable* by the Employee at the end of the Plan Year, except for claims incurred during the Plan Year and submitted within three and one-half (3 1/2) months after the end of that Year. Unused amounts *cannot be carried forward* into the next plan year and *will be forfeited* for the current and all subsequent Plan Years.
- Once deduction amounts are elected, *the election is not revocable* except as provided in the Plan.
- Once an employee has elected to participate in the Plan, he/she shall be deemed to have continued his/her election in subsequent Plan Years, in the amounts and on the terms previously elected, unless he/she elects to change or discontinue his/her participation in the manner set forth in the Plan, or unless he/she is no longer eligible to participate.

PLAN YEAR DATES COMMENCING **October 1st 2009** ENDING **September 30th 2010**
 I HEREBY REQUEST PARTICIPATION IN OUR SECTION 125 PLAN AND ELECT THE FOLLOWING CONTRIBUTION AMOUNTS TO BE PAYROLL DEDUCTED IN THE CATEGORIES AS INDICATED

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|-------------------------|---------------------------|---|
| SALARY REDUCTION | PREMIUM CONVERSION | <input type="checkbox"/> PREMIUM CONVERSION ACCOUNT |
| | | Medical \$ _____ Other \$ _____ Other \$ _____ Carrier _____ Carrier _____ Carrier _____ # of Pays _____ # of Pays _____ # of Pays _____ Total PLAN YEAR Premium Contributions: \$ _____ • If, as, and when the insurance contributions increase in my Premium Conversion Account, I authorize the Employer to further reduce my salary by the corresponding amount to match my current level of coverage. |

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| SALARY REDUCTION | REIMBURSEMENT ACCOUNTS | <input type="checkbox"/> FLEXIBLE SPENDING ACCOUNT |
| | | <input type="checkbox"/> MEDICAL CARE REIMBURSEMENT ACCOUNT Payroll Reduction Amount: \$ _____ Per Pay Period, X _____ Periods = \$ _____ Annually <input type="checkbox"/> DEPENDENT CARE REIMBURSEMENT ACCOUNT Payroll Reduction Amount: \$ _____ Per Pay Period, X _____ Periods = \$ _____ Annually TOTAL PLAN YEAR CONTRIBUTIONS \$ _____ |

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| PAYMENT OPTION | <input type="checkbox"/> DIRECT DEPOSIT: Your Section 125 reimbursements will automatically be deposited to your checking or savings account. By choosing this option I give MEBS the authorization to initiate credit entries to my personal bank account. This authority is to remain in effect until MEBS has received written notification of its termination. |
| | • You MUST attach a voided check or savings withdrawal ticket to your enrollment form. |

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| PLAN ELECTION | TO PARTICIPATE | <input type="checkbox"/> YES |
| | | • I have read and understand the information provided, and wish to participate in the Section 125 Plan. Employee Signature _____ Date: _____ |

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| PLAN ELECTION | TO DECLINE | <input type="checkbox"/> NO - SIGN THIS SECTION ONLY IF YOU ELECTED TO DECLINE THE SECTION 125 PLAN |
| | | • I have been given the opportunity to enroll in this plan, but I do <u>not</u> wish to participate during this Plan Year. Employee Signature _____ Date: _____ |

THIS FORM **MUST** BE COMPLETED AND RETURNED TO YOUR ADMINISTRATOR BY **SEPTEMBER 15, 2009**