



ENROLLMENT FORM

Plan Year

Please complete form, sign, and return to CPI. Contact information below.

EMPLOYEE INFORMATION					
Employee Name:	Last Name		First Name		Middle Initial
Social Security Number:	Date of Birth:		Gender:		
Home Address:	Street		City	State	Zip Code
Email Address:	Telephone #:				
EMPLOYER/BENEFITS INFORMATION					
Employer Name:	Date of Hire:				
Plan Effective Date:	Date of 1 st Payroll Deduction:				
Insurance Carrier Name:	Payroll Frequency:				
PLAN ELECTIONS					
Plan Type	Annual Election (\$)	Number of Payrolls	Amount per Pay Check (\$)	Employer Contribution (if applicable)	
				Per Month	Per Year
☐ Healthcare Flexible Spending Account (FSA):					
☐ Dependent Care FSA:					
☐ Limited Plan FSA (Dental and Vision Only):					
☐ Health Reimbursement Arrangement (HRA):					
☐ Transit Plan:					
☐ Parking Plan:					
FOR DEPENDENT COVERAGE:		Married? ☐ Yes ☐ No Dependent Children? ☐ Yes ☐ No		If Yes, list your spouse and dependent children below:	
Last Name	First Name	Social Security Number*	Relationship to Employee	Date of Birth*	Gender
AUTHORIZATION					
I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming expenses 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 qualified expenses incurred during the Plan Year will be forfeited in accordance with current Plan provisions and tax laws. Furthermore, I agree that the IRS regulations state four conditions: (1) any expenses I/we incur must be within the Plan Year; (2) any expenses I/we incur must not be covered by any other sources, such as insurance; (3) I/we must provide proper documentation to receive payment; (4) I/we cannot change or revoke elections during the Plan Year unless there is a specific change in status and my employer allows such changes. Please see Summary Plan Description for details.					
Employee Signature _____			Date _____		
* Social Security and date of birth for employees and their dependents are required for HRA reporting purposes for Medicare and Medicaid Services as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Enrollment Forms without this required information will be returned for completion.					
DECLINING COVERAGE					
The benefits of the Cafeteria Plan have been presented and explained to me and I decline to participate. I understand that I cannot enroll in the Plan until the beginning of the next Plan Year or until I have a Change in Status that would allow me to change my election.					
Employee Signature _____			Date _____		