MEBS
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SECTION 125 ENROLLMENT FORM

MEBS, Inc. - 3809 Lake Eastbrook Blvd. - Grand Rapids, MI 49546
(616) 458-6327 - FAX (616) 458-3495 - (800) 968-9682

BASIC INFORMATION

BAY ARENAC I.S.D

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 $ _____

DEPENDENTS

Name	Date of Birth	Social Security Number	Sex	Relationship To Employee	Dependent's Employer

IMPORTANT

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 ($3\frac{1}{2}$) 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: _____ ENDING: _____

I HEREBY REQUEST PARTICIPATION IN OUR SECTION 125 PLAN AND ELECT THE FOLLOWING CONTRIBUTION AMOUNTS TO BE PAYROLL DEDUCTED IN THE CATEGORIES AS INDICATED:

SALARY REDUCTION

CASH OPTION

☐ **CASH OPTION:** In lieu of the Employer Provided Group Medical Insurance, I elect the following amount: $_____

- I acknowledge that the coverage provided through my alternative medical plan may not be equal in all areas to the Employer's medical plan. I have had the opportunity to review the Employer's medical plan in detail.

PREMIUM CONVERSION

☐ **PREMIUM CONVERSION ACCOUNT**

Medical $_____	Dental $_____	Vision $_____	Other $_____	Other $_____
Carrier _____	Carrier _____	Carrier _____	Carrier _____	Carrier _____
# of Pays _____	# of Pays _____	# 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.

REIMBURSEMENT ACCOUNTS

☐ **FLEXIBLE SPENDING ACCOUNT**

☐ MEDICAL CARE REIMBURSEMENT ACCOUNT

Payroll Reduction Amount: $_____ Per Pay Period, X ___ Periods = $_____ Annually

☐ DEPENDENT CARE REIMBURSEMENT ACCOUNT

Payroll Reduction Amount: $_____ Per Pay Period, X ___ Periods = $_____ Annually

TOTAL **PLAN YEAR** CONTRIBUTIONS $_____

PAYMENT OPTION

☐ **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.

PLAN ELECTION

TO PARTICIPATE

☐ **YES**

- I have read and understand the information provided, and wish to participate in the Section 125 Plan.

Employee Signature _____ **Date:** _____

TO DECLINE

☐ **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 not wish to participate* during this Plan Year.

Employee Signature _____ **Date:** _____

THIS FORM *MUST* BE COMPLETED AND RETURNED TO BAY ARENAC ISD BY DECEMBER 15