HealthComp
Third Party Administrators

FLEXIBLE BENEFITS ENROLLMENT/CHANGE FORM

Mail to: HealthComp, Inc. P. O. Box 45018, Fresno, CA 93718-5018 (559) 499-2450 or (800) 442-7247 Fax (559)499-2045

This form is submitted for: ☐ New Enrollment ☐ Name Change ☐ Address Change ☐ Termination ☐ Birth/Adoption
☐ Marriage ☐ Divorce ☐ Termination of Spouse's Employment ☐ Other_____

EMPLOYEE INFORMATION

Employer Employee's Telephone #

Employee's Name Social Security #

Employee's Address

_____State_____Zip_____

Date of Hire Date Eligible To Participate Employment Status

_____ _____ ☐ FT ☐ PT ☐ TEMP ☐ _____

PREMIUMS

I request the following health benefits be deducted Pre-Tax (**Per pay period):**

☐ Medical Premium . . . . . $_____ ☐ Dental Premium . . . . . $_____
☐ Vision Premium . . . . . $_____ ☐ Life Premium . . . . . $_____
☐ Disability Premium . . . . . $_____ ☐ Other Premium . . . . . $_____

SPENDING ACCOUNTS

I request the following benefits be payroll deducted Pre-Tax **(Per pay period):**

Dependent Care $_____ (Annual) $_____ (Pay Period)
Unreimbursed Medical $_____ (Annual) $_____ (Pay Period)

CHANGE IN FAMILY STATUS

Action Desired: ☐ **Terminate Participation** ☐ **Change the following Pre-Tax Payroll Deduction**

☐ Eligible Premium . . . . . from $_____ to $_____
☐ Unreimbursed Medical . . . . . from $_____ to $_____
☐ Dependent Care . . . . . from $_____ to $_____

TERMINATION OF EMPLOYMENT

Employee's Termination Date: **Effective Date of Change:**

DECLARATIONS

☐ I hereby request **participation** in the above plan. I also certify the above information to be correct and true to the best of my knowledge and that the expenses for dependent care and/or unreimbursed medical are for myself and my dependents. I also understand that any amounts remaining in my Spending Account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan document provisions and tax laws. I further understand that the deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status.

☐ I hereby **decline** participation in the above plan.

Employee's Signature_____ Date_____