

Onondaga Employee Leasing

Benefits Administered By
 Upstate Admin. Svcs, Inc. a division of MVP Select Care
 620 Erie Blvd. West #200, Syracuse, NY 13204
 (315) 422-1533 ❖ 1-800-788-8771

Employee Choice Plan Enrollment / Change Form Plan Year: January 1, 2008 – December 31, 2008

- Regular Annual Election
 Mid-Year Election (New Employee)
 Change in Family Status

If Mid-Year Election, date of first payroll deduction:
 If change of family status, date of event: _____ Date of first payroll deduction after change becomes effective:
 If change in family status, change is due to: Divorce/separation
 Marriage Birth or Adoption of child Death of spouse/child
 Spouse becomes employed Spouse ceases to be employed
 Change in work hours Unpaid leave of absence Other (explain below):

EMPLOYEE INFORMATION (please print)	
Employee Name (last, first, middle initial)	Employer Name Division/Location
Street Address	How often are you paid? <input type="checkbox"/> Weekly (52/Yr) <input type="checkbox"/> Bi-Weekly (26/Yr) <input type="checkbox"/> Semi-Monthly (24/Yr) <input type="checkbox"/> Monthly (12/Yr) <input type="checkbox"/> Other (explain):
City, State, Zip	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated
Soc. Sec. Number Birthday	Do you want Direct Deposit <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, fill out separate Direct Deposit enrollment form if new enrollee or bank information <u>has changed</u> from previous year
PLAN YEAR ELECTIONS - PRE-TAX SALARY REDIRECTIONS	

I authorize my employer to deduct pre-tax contributions from my compensation for the following benefits: Premiums for my group plans offered by my employer (group medical plan, etc) Dependent Care Reimbursement Account (day care expenses for eligible dependents) Health Care Reimbursement Account (reimbursement for family health care expenses not paid from any other source).
If you have elected to pay your group plan Premiums under this Plan, the full amount of your premiums due per pay cycle will be deducted from your compensation on a pre-tax basis. The amount will depend upon which group benefits you participate in.

<i>NOTE: All contributions to Plan are subject to forfeiture if not claimed within 60 days after end of Plan Year!!</i>	Pre-Tax Deductions	
	Per Pay Period Deduction	Total Annual Deduction
Health Care Reimbursement ■		
Dependent Care Reimbursement ◆		
TOTALS		

■ The maximum amount of Health Care Reimbursement Account contributions allowed is \$1500.00 annually. ◆ If married & filing federal income taxes jointly, the maximum amount of contributions to the Dependent Care Reimbursement Account is \$5,000; if married & filing separate returns, the maximum amount is \$2,500 annually. Amounts contributed to the Dependent Care Reimbursement Account reduce any available federal Child Care Credit.

AUTHORIZATION OR WAIVER OF PARTICIPATION

I request to participate in the benefits indicated above and hereby authorize my employer to make pre-tax deductions from my compensation in the amounts indicated. I understand that my elections indicated above are binding upon me for the entire Plan Year and cannot be revoked, modified or amended unless due to very limited changes in family status as described within the Plan. I further certify that any dependents for whom I will be claiming dependent care or health care expenses will be claimed by me as dependents on my federal and state tax returns. I further understand that future Social Security benefits may be affected should I elect pre-tax salary deductions under this Plan. If I have waived participation, I understand that I may not join the Plan until the start of the next plan year.

Employee Signature _____ Date _____

Employer Signature _____ Date _____