

My Personal Information

| | | |
|-------------------------|--|-------------------------|
| First Name | Middle Initial | Last Name |
| Home Address | City | State |
| | | Zip |
| Home Phone | E-mail Address (We do not share your e-mail address) | Social Security Number |
| Birth Date (mm/dd/yyyy) | Gender M F | |
| Employer | Department Name/Location/No. (if applicable) | Date Hired (mm/dd/yyyy) |

My Plan Dates (Refer to "My Company Plan" Eligibility section)

| | | |
|-------------------------|--------------|---|
| My Effective Start Date | My Plan Year | Number Of Payroll Deductions From My Effective Start Date To End Of Plan Year |
|-------------------------|--------------|---|

Mid-year Enrollment (Leave blank if not applicable)

Choose one:

Met waiting period Merger/acquisition

My BESTflexSM Plan Benefits

Group Insurance Premiums

If you participate in your employer's insurance plan(s), your premiums will be automatically deducted from your pay before taxes unless you notify your employer otherwise.

My BESTflex Plan Accounts

Your annual amount will be rounded down if it isn't evenly divisible by the number of paychecks.
(\$1200 ÷ 24 = \$50.00: no rounding down; \$1200 ÷ 26 = \$46.15: rounded down to the nearest penny)

| | Plan Year Total | No. of Paychecks | Deduction per Paycheck |
|---|-----------------|------------------|------------------------|
| I request the following amounts to be deducted, pre-tax: | | | |
| Health Care FSA | ÷ | | = |
| Dependent Care FSA (Maximum contribution: \$ 5000.00) | ÷ | | = |
| Employee Paid Administrative Fees (if any) | ÷ | | = |
| Totals: | ÷ | | = |

Yes, I want to save tax dollars!

I agree this election cannot be revoked or changed during the plan year, unless there is a qualifying event that justifies the revocation or change as authorized by the IRC and Regulations. I understand that my Social Security benefits may be affected by my participation in this Plan and that any money I allocate to these accounts and do not spend by the end of the plan year (or grace period, if elected by the plan sponsor) cannot be returned to me. If a debit card has been provided to me, I certify that I will only use the Card for payment of eligible expenses under the Plan and that any expense paid with the Card will not be reimbursed nor will I seek reimbursement under another Plan. I agree, when necessary, to provide substantiation that any particular expense is eligible for reimbursement under the Plan, and to reimburse the Plan in cases where I have been erroneously or wrongfully reimbursed for an expense that is not eligible for reimbursement under the Plan. I also understand that, to provide services to my employer in connection with one or more employee benefit plans maintained by my employer, Employee Benefits Corporation may need "protected health information" regarding coverage or benefits to me or my dependents under the Plan. By signing this Enrollment Form, I hereby acknowledge that Employee Benefits Corporation will obtain "protected health information" for purposes of the Plan and only for as long as Employee Benefits Corporation is providing services regarding the Plan. Any information disclosed pursuant to this Enrollment Form will not be subject to redisclosure by the recipient, except for purposes of the Plan. I understand that my enrollment can be denied if I do not sign this form.

X _____ / /
Signature Date (mm/dd/yyyy)

No, I do not want to participate.

I understand that I have been given the opportunity to enroll in the BESTflex Plan Flexible Spending Accounts with my employer on this date. I have elected not to do so in this plan year. I also understand that if there is a qualifying event, I may have a right to sign on to the Plan at that time.

X _____ / /
Signature Date (mm/dd/yyyy)

Web Address:
www.ebcflex.com

U. S. Mail:
Employee Benefits Corporation
PO Box 44347
Madison WI 53744-4347

Phone:
Monday - Friday, 8:00 - 5:00 CST
608 831 8445
800 346 2126

Fax:
608 831 4790

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