Enrollment Form

Medical and/or Dependent Care Flexible Spending Arrangement

Plan Year: January 1, 2012 – December 31, 2012

☐ **Current 2011 Participant (complete name only-unless other personal information has changed)**

Employee Data

Employer Name: **MH HOLDING COMPANY, INC.**	
Employee Name:	Social Security Number:
Mailing Address:	Daytime Phone:
City, State, Zip:	Evening Phone:
E-mail Address:	Date of Hire:

May 125MAX communicate with you via email? (i.e. HIPAA Privacy Notice, EOBs, etc.) ☐ Yes ☐ No

List All Tax Dependents (spouse, children, etc.) *Need birth dates for all dependents* ☑ = dependent child under 26

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth
			☐		
☐			☐		
☐			☐		

Type of Election and Current Coverage

Type of Election: ☐ Open Enrollment ☐ Family Status Change ☐ New Hire

New Hire (only) Date of Eligibility: First Contribution (payroll date):

Health FSA Election: ☐ Traditional Health FSA (employee and spouse ineligible for HSA)

For those with HDHP and considering HSA

☐ Traditional Health FSA for employee only, or employee plus children (preserves spouse's HSA eligibility)

☐ Limited scope/Post-Deductible Health FSA (dental/vision expenses and medical expenses after minimum statutory high deductible is met – preserves ee and spouse's HSA eligibility)

Participant's Premium Only Contributions

Deduct Premium Contributions Pre-Tax: ☐ Yes ☐ No Total Per Paycheck Contribution: $

Current Coverage (Check all that Apply) ☐ Medical ☐ Dental ☐ Vision ☐ Other:

Participant's Flexible Spending Arrangement Request

Please indicate desired participation for the current Plan Year. This election may not be changed during the Plan Year unless a qualified family status event occurs.

Health Flexible Spending Arrangement

☐ I **do** wish to participate ☐ I **do not** wish to participate

Plan Year Maximum: $ 5,000.00*
Plan Year Minimum: $ 500.00

Annual Election ÷ # of Payrolls = Pay Period Amount

$ ____________ ________ $ ____________

This election is for eligible medical expenses for you and/or your spouse and dependents. For example; acupuncture, co-pays, eyeglasses, prescription drugs, and certain over-the-counter purchases.

- Premium contributions **should not** be counted.
- For plan information and/or on-line web access info please visit our website at: www.125max.com.
- ***Be advised this amount will be capped at $2,500 with the start of the next plan year due to health care reform.**

Dependent Care Flexible Spending Arrangement

☐ I **do** wish to participate ☐ I **do not** wish to participate

Plan Year Maximum: $ 5,000.00*
Plan Year Minimum: $ 500.00

Annual Election ÷ # of Payrolls = Pay Period Amount

$ ____________ ________ $ ____________

***If you are married and filing separately, your childcare maximum election is $2,500.00.**

This election is for eligible dependent care expenses (daycare, childcare, or elder care). This election **should not** be used for medical expenses for your dependents. You must actually be at work while your eligible dependent is provided care. If you are married, both you and your spouse must be working while care is provided to your eligible dependent. Generally, one of the following eligibility guidelines must be satisfied.
* Your spouse must be working outside the home (if you are married); or
* You must be a single parent; or
* Your spouse must be a full-time student at least five months during the year while you are working; or * You are divorced and the child is in your custody.

Employee Certification

I have read and understand the 125MAX Health and/or Dependent Care Flexible Spending Arrangement Plan guidelines as outlined in the Enrollment Packet and I understand the restrictions that apply to eligible expense reimbursement requests. *Further, I understand that the above salary reduction request which will be allocated to my Flexible Spending Arrangement will be forfeited according to current plan provisions and tax laws if I do not incur and appropriately submit any eligible expenses within the Plan Year.* I certify the above information to be true and that the dependents that I intend to claim expense reimbursements for are legally dependent on me for their support as defined by current tax law. I agree to have my compensation reduced by the amounts indicated above. I understand that my election to reduce my compensation could affect my Social Security benefits and other wage-based social insurance programs. I further understand that the deduction elections indicated above will remain in effect for the entire Plan Year and cannot be changed or revoked unless I experience a qualified change in family status as defined by the law. I understand that my signature on this enrollment form constitutes a formal salary reduction agreement between my Employer and me.

Date:	Participant Signature:

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