



NORTH IDAHO COLLEGE

ENROLLMENT FORM - Plan Year Beginning 7/1/2007

Please PRINT Clearly

| | | | | | |
|--|---|---|---------------|--|---------------------|
| Employer North Idaho College | | Dept. Name/Location | | No. of Payroll Deductions from Effective Date to End of Plan Year: | |
| Employee's Name (Last, First MI) | | | | Social Security Number / / | |
| Employee's Home Address | | City | State | Zip | Home Phone |
| Birth Date / / | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | Spouse's Name | | Date of Hire / / |
| Employee E-mail Address | | Employer Complete Date of First Deduction | | Employer Complete Employee Effective Date for Plan | |

I request the following amounts to be deducted pretax:

A. Group Medical Premium If you participate in your employer's insurance plan(s) your premiums will automatically be deducted pre-tax unless you notify your Human Resource Department otherwise.

| Reimbursement Sections: | Plan Year Total | # of Paychecks | \$ Per Pay Check |
|---|-----------------|----------------|------------------|
| B. Health FSA Minimum: 0.00 Maximum: 10,000 | _____ ÷ | _____ = | _____ |
| C. Dependent Care Minimum: 0.00 Maximum (Single): 2500.00 Maximum (Family): 5000.00 | _____ ÷ | _____ = | _____ |
| D. Individual Health Policy | _____ ÷ | _____ = | _____ |
| TOTALS: | _____ ÷ | _____ = | _____ |

No, I do not want to enroll in the reimbursement plans. If a change of status occurs, I may have the right to sign on the plan at that time if my employer's plan allows.

Signature: X _____ Date: _____

Yes, I want to enroll. The IRS regulation states four conditions. 1.) Any expenses you incur must be within the plan year. 2.) Any expenses you incur must not be covered by any other source such as insurance. 3.) You must provide proper documentation in order to receive payment. 4.) You cannot change or revoke your elections during the plan year unless there is a specific *Change of Status* and your employer allows such changes. Please see the Summary Plan Description. (Note: Enrolling may have a minor effect on your social security benefits. Please seek appropriate advice.) **Prior to each plan year, I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at that time, I will continue having my current election amounts plus any applicable increases, deducted from my pay for the new plan year.**

Signature: X _____ Date: _____



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