ROCKY MOUNTAIN ADMINISTRATORS
809 South Railway Avenue – P.O. Box 788
Worland, WY 82401
Phone – 307-347-2606   Fax – 307-347-2646

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

____
Employer   Group Number   Date of Hire

____
Employee's First Name   M.I.   Last Name   Date of Birth   Sex (M/F)

____
Employee Mailing Address   City   State   Zip Code   Phone Number

____________________________________   _______/_______/_______
Employee Personal Identification Number   Effective date of Coverage

(1) I authorize my eligible premiums to be withheld pretax ☐

(2) Unreimbursed Medical Expenses ☐   Annual Pledge $_________   Per Pay Deduction $_________

(3) Dependent Care Expense ☐   Annual Pledge $_________   Per Pay Deduction $_________

(4) Other Pre-Tax Premiums (Life, Disability, etc.)   ☐ Life   ☐ Disability   ☐ Other

____
Please specify

(5) Other After-Tax Premiums $________   ☐ Life   ☐ Disability   ☐ Other

____
Please specify

☐ Please check here if you have a secondary health or dental plan that pays after your primary. Your account will be set to not transfer from your Medical Plan to the Flexible Spending Account.

NOTE: Funds will be accounted for separately and cannot be interchanged for items 2 & 3.

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the plan year and cannot be revoked unless I experience an eligible change of status as defined under the terms of my employer's plan.
Signature: _______________________________________ Date: ___________________

DECLINATION OF PARTICIPATION: I have been given the opportunity to participate in the above plan and have elected not to do so. I understand that I will not be given another opportunity to sign up until the next open enrollment.
Signature: _______________________________________ Date: ___________________

INFORMATION SUPPLIED BY EMPLOYER THIS MUST BE FILLED OUT FOR DISCRIMINATION TESTING:

Frequency of Pay: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other
First Pay Date of Deductions: _____________________
Premiums per pay period for HEALTH: ______________________ Other: _______________________
☐ 5% Owner ☐ Key Employee ☐ Highly Compensated Employee