

Employee Benefit Management Services, Inc.

P.O. Box 21367, Billings, MT 59104-1367
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CAFETERIA PLAN ENROLLMENT FORM

SECTION A:

Employer		Type of Plan (Check One) <input type="checkbox"/> Employee <input type="checkbox"/> Employee and Dependents			Enrollment (Check One) <input type="checkbox"/> New <input type="checkbox"/> Change	
Employee's Last Name	First Name	M.I.	Gender	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		
Social Security Number - -			Date of Birth / /			
Current Mailing Address						
Street		City		State		Zip
Do you have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If you or any of your eligible dependents are eligible for other health benefits coverage, please provide the name, address and policy number of the insurance carrier.						
List of Eligible Dependents						
Last Name	First Name	M.I.	Social Security Number	Gender	Date of Birth	Relationship to Employee
Spouse			- -		/ /	
			- -		/ /	
			- -		/ /	
			- -		/ /	
			- -		/ /	
			- -		/ /	
			- -		/ /	

SECTION B:

Plan Year _____ through _____.

Employer and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

I elect to receive the following coverages under the Cafeteria Plan:

COVERAGE (X if yes)	ANNUAL AMOUNT	AMOUNT PER PAY PERIOD
_____ Medical care reimbursement	\$ _____	\$ _____
_____ Dependent care assistance	\$ _____	\$ _____
_____ Health Savings Account	\$ _____	\$ _____
_____ Health insurance premium	\$ _____	\$ _____
_____ Dental insurance premium	\$ _____	\$ _____

Note: There may be limits on the amounts which can be used for certain benefits. You should review your Summary Plan Description and ask the plan administrator if you have any questions. Also, to complete the above, first determine your annual contribution for each benefit selected. Then, divide that amount by the number of pay periods remaining the Plan Year and write that amount in the Amount Per Pay Period column. With regard to my salary reduction agreement and my election of benefits, I understand that:

- I may not change election during the Plan Year unless there is a change in my family status (e.g. termination of employment or change to part time status by either myself or my spouse, marriage, divorce, death of my spouse or child, adoption or birth of my child), with the exception of my HSA contribution.
- The Administrator is authorized to adjust the amount of my salary reduction and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
- My election of salary reduction and benefits will remain in effect only for the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for the Plan Year.
- Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year, with the exception of the Health Savings Account.
- My Social Security benefits may be reduced as a result of my election.
- Signing this Agreement does not initiate my coverage under the insurance policies. I must complete a separate health insurance enrollment form to start my health insurance coverage.

THIS AGREEMENT IS: 1. SUBJECT TO THE TERMS OF THE COMPANY'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME; 2. SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS; 3. SHALL TAKE EFFECT UNDER APPLICABLE LAWS; AND 4. REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

Signature _____ Date _____

DECLINATION OF PARTICIPATION I have been given the opportunity to participate in the Cafeteria Plan and have elected not to do so.

Signature _____ Date _____