



# NCFlex Enrollment Form

Plan Year 2008

- FSA
  - Den
  - Vis
  - Cancer
  - AD&D
  - Life
- Leave Blank

**EMPLOYING UNIT MUST COMPLETE**

Payroll Unit Number: \_\_\_\_\_ New Employee:  Yes  No Date of Hire/Rehire (mo/day/yr): \_\_\_\_\_

Payroll Freq:  Monthly (12 checks per year)  Semi-Monthly (24 checks per year)  Bi-Weekly (26 checks per year)

(check **one**)  Bi-Weekly with monthly deductions (26 checks per year)  Other Frequency: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**EMPLOYEE INFORMATION (Please Print)**  Male  Female

Name:(Last) \_\_\_\_\_ (First) \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth: \_\_\_\_\_ mm dd yy

SSN: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Agency/Univ/Comm Col: \_\_\_\_\_

Home Address: \_\_\_\_\_ (area code) City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**FLEXIBLE SPENDING ACCOUNTS (FSAs)\* (TO CONTINUE YOUR FSA, YOU MUST RE-ENROLL EVERY YEAR)**

Annual Health Care FSA Contribution: \$ \_\_\_\_\_  
(Annual minimum \$120; Annual maximum \$4200)

Annual Dependent Day Care FSA Contribution: \$ \_\_\_\_\_  
(Annual minimum \$120; Annual maximum \$5000)

\*FSA payments are issued by Direct Deposit to the account your payroll check is deposited.

Check here to decline Direct Deposit.

**DENTAL PLAN**  New  Change  Cancel

Plan Options (check one):  LOW OPTION  HIGH OPTION

Coverage Levels (check one):  Employee Only  Employee + One Child  Employee + Two or More Children  Employee + Spouse  Family

**VISION CARE PLAN**  New  Change  Cancel

Plan Options (check one):  Plan 1  Plan 2

Coverage Levels (check one):  Employee Only  Employee + Family

**CANCER INSURANCE**  New  Change  Cancel Complete EOI Form Online.

Plan Options (check one):  LOW OPTION  HIGH OPTION

Coverage Levels (check one):  Employee Only  Employee + Family

Name (Last, First, MI) Complete only if enrolling in Dental/Vision/Cancer	Gender		Date of Birth	Full-Time Student		Add/Drop	NCFlex Plans Selected		
	M	F		Y	N		Dental	Vision	Cancer
Spouse _____	<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child (1) _____	<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child (2) _____	<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child (3) _____	<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child (4) _____	<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child (5) _____	<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE**  New  Change  Cancel Complete Beneficiary at Right.

Plan 1 Employee Only  Aviation Pilot/Crew Member-Plan 1 Employee Only

Plan 2 Employee & Family  Aviation Pilot/Crew Member-Plan 2 Employee & Family

Insurance Amount \_\_\_\_\_ Monthly Cost \$ \_\_\_\_\_

AD&D BENEFICIARY	RELATIONSHIP TO EMPLOYEE	% OF BENEFIT
Full Name(s)		
Primary:		
Contingent:		

**GROUP TERM LIFE INSURANCE**  New  Change  Cancel Complete Beneficiary at Right and Submit EOI Form Online.

Insurance Amount \_\_\_\_\_ Monthly Cost \$ \_\_\_\_\_

TERM LIFE BENEFICIARY	RELATIONSHIP TO EMPLOYEE	% OF BENEFIT
Full Name(s)		
Primary:		
Contingent:		

**EMPLOYEE AUTHORIZATION**

I hereby elect coverage under NCFlex as listed above for myself and eligible family dependents. I understand that by participating in NCFlex my Social Security Number will be used for tax identification purposes and my pay will be reduced by the amount of my pre-tax elections. **I understand that, in accordance with IRS regulations, I cannot change or cancel my elections or contributions during the Plan Year unless I have a qualifying status change. I understand that any amounts contributed to the Flexible Spending Accounts which I do not use for expenses incurred during the Plan Year will be forfeited.** I certify that the above information is true and accurate to the best of my knowledge.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please make a copy for your records then return completed ORIGINAL form to your HBR or benefits department.**