KLERER FINANCIAL SERVICES, INC.

3272 Merrick Road, Wantagh, New York 11793-4339

Insurance & Investments
Employee Benefit Plans
Financial Planning

Phone: (516) 409-5500
Fax: (516) 409-6100
E-mail: kfs@klerer.com

ENROLLMENT FORM

PLAN YEAR:	to:	☐ New	☐ Re-enrollment
COMPANY NAME:			

EMPLOYEE NAME:				
Address	City		State	Zip
Social Security #:	Phone #:			
Date of Birth:	Date of Hire:	Sex:	☐ Male	☐ Female
Pay Period:	☐ Weekly	☐ Bi-Weekly	☐ Semi-monthly	☐ Monthly
First Payroll Deduction:		No. of Pay Periods in Plan:		

Medical Expense Account
$_____ per pay period $_____ annual amount

Dependent Care Account
$_____ per pay period $_____ annual amount

I understand that:

***My compensation each pay period will be reduced by the total amount above divided by the number of pay periods in the year (or remaining in the year if you are becoming a participant at any time except at the beginning of the Plan Year).

***I cannot change or revoke this benefit election or Compensation Reduction Agreement as of any date prior to the next January 1st, unless I have a change in family status (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Administrator determines will permit a change or revocation of an election).

***Prior to January 1st each year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected cash instead of salary reduction for the new Plan Year (January 1st to December 31st). In addition, this Compensation Reduction Agreement will continue by its terms in the amount of the elected contribution.

***The Administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the provisions of the Plan if it is believed to be advisable in order to satisfy certain provisions of the Internal Revenue Service.

***The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans.

***This election will automatically be canceled as of the date I terminate employment. However, if I continue to be covered under the Employer's medical plan, I may be able to continue participation in this Plan during my period of coverage. I will receive information on this option when I terminate service.

_____ _____
Employee Signature Date

WAIVER OF PARTICIPATION

I have been given the opportunity to participate in the Flexible Benefits Program. I also understand that if I refuse the Flexible Benefit Plan at this time, I will not have the opportunity to join the Plan until the next enrollment period.

_____ _____
Employee Signature Date