

**Morgan-White Administrators, Inc.**  
*Flex Benefit Enrollment Form*

EMPLOYER: \_\_\_\_\_

Employee's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Annual Salary \$ \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Additional card for dependent (must be 18 years old or older).

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Reimbursement Type	Pay Period Deduction	Annually
1. Health Reimbursement Arrangement	\$ N/A	\$
2. Flexible Spending Account	\$	\$
3. Dependent Care Account	\$	\$
<b>Total Pre-Tax Dollars</b>	\$	\$

No change or revocation of this Participation Agreement can be made at any time during the plan year unless there is a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of spouse's employment and such other events as the administrator determines will permit a change or revocation). Employee understands that changes in the group rates eligible under this plan will be automatically adjusted for the participant's election.

The employee agrees on demand to indemnify and reimburse the employer for any liability that may incur from failure to withhold federal and state income tax or social security tax.

*I have read the explanation of the Flexible Benefit programs and understand my benefit choices. I authorize the selections I have made as well as the salary reductions required for those selections. I understand that the above selections are effective for the entire year unless I experience a recognized change in status. I also understand any monies placed into either the Flexible Spending or Dependent Care Accounts that are not used by the end of the plan year will be forfeited. Finally I understand that the amount I have elected to contribute to the Dependent Care Account cannot exceed the amount of my income or my spouse's income, whichever is less. I understand that this benefit may qualify for COBRA if my employment is terminated.*

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee's Email Address: \_\_\_\_\_

<b>Declination of Coverage</b>	
I hereby acknowledge that I have been given the opportunity to participate in the Flexible Spending Account Plan sponsored by my employer. The benefits have been explained to me and I decline to participate in the program at this time.	
Date _____	Signature _____

**Morgan-White Administrators, Inc.**

P.O. Box 14067, Jackson, MS 39236, (601) 956-2028, Toll Free: 1-800-800-1397, Fax: (601) 956-3795