



Rocky Mountain
Employee Benefits, Inc.

ALLIANCE BENEFIT GROUP

Roman Catholic Bishop of SLC 125 Plan
Enrollment Form

Location: _____
Plan Year: January 1, 2010 through December 31, 2010

EMPLOYEE INFORMATION (PLEASE PRINT CLEARLY)

Employee Last Name	First Name	Middle Name	Social Security Number
_____	_____	_____	____-____-____

Street (include apartment number) _____

City	State	Zip Code + 4
_____	_____	____-____

Email Address	Date of Hire	Date of Birth
_____	____/____/____	____/____/____

Additional Card Issued To Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
_____	_____	_____	____-____-____	____/____/____

ELECTIONS

Health FSA

I elect to participate. Protect \$_____ annually from taxes (\$6,000 annual maximum)

I do not elect to participate. I elect to have a Benny Visa Debit Card (\$20 charge)

Dependent Care FSA

I elect to participate. Protect \$_____ annually from taxes (\$5,000 annual maximum)

Your FSA enrollment materials fully describe the qualification criteria for dependent care expenses.

I do not elect to participate.

Premium Elections (default is pre-tax election)

I elect to participate and understand that I may only change insurance coverage if I have a qualifying change in status, or at the next anniversary date of January 1.

I waive my participation

Protect premium payments for:

- Health & Medical Plan
- AFLAC (excluding ST disability)
- Other – please specify

AUTHORIZATION

I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my elections above, with the "tax protected" funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year, unless I experience an eligible change in status. I further understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year. Any unused amounts remaining in my account at the end of the plan year will be forfeited. However, I will have a specified period of time (indicated on the FSA Highlights) after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year on employment end. My Social Security benefits may be reduced by this election.

I also certify that I, and my spouse and/or dependent(s) if applicable, will only use the Flexible Spending Account Card that I will receive in connection with the employer's Health Care Flexible Spending Account Plan and in Section 213 of the Internal Revenue Code. I further certify that I will not seek reimbursement from any other plan for medical expense paid with the Flexible Spending Account Card, nor will I claim any federal income tax deduction with respect to such expense.

Employee Signature X _____ Date _____

TO BE COMPLETED BY EMPLOYER

Medical Plan		AFLAC Plan A		AFLAC Plan B		AFLAC Plan C	
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