Benefit Plan Participation Form

Employer: Colorado Mesa University Plan Year: 2020

Initially enroll or annually re-enroll in the Cafeteria Plan & Section 125 Plan

Plan Effective Date:_____/_____/_____

Participant Data (All fields are required)

Employee Name:_____ SSN: _____
Last First M.I.

Address: _____
Street City State Zip

Email:_____ Phone:_____ Date of Birth: _____
mm/dd/yyyy

Section 125: Insurance Premiums (check one)

☐ **Pre-Tax** I elect to reduce my gross wages and have all my selected eligible health, dental, and/or vision premiums paid on my behalf with before-tax dollars. Once elected, this before-tax payment will continue throughout this Plan Year until I sign a waiver. This waiver can only be signed during Open Enrollment or due to Status Change during the Plan Year.

☐ **Post-Tax** I do not want to pay my portion of the eligible premiums with before-tax dollars.

Flexible Spending Accounts (FSA)

I elect to reduce my compensation for each pay period during the plan year (or during such a portion of the year as remains after the date of this agreement) and redirect such dollars into the Benefit Plan as set forth below.

	Annual Election $	# of Pay Periods	Semi-Monthly Pay Period Deduction $
Medical FSA			
Dependent Care FSA			
Limited Purpose FSA			

Signature and Authorization

I hereby certify I have read and understand the Terms and Conditions of this Plan which appear at the link http://goo.gl/AXVASm and in the Summary Plan Description and agree to abide by said Terms and Conditions. If waiving participation, I hereby certify I fully understand the benefits available to me under this Cafeteria Plan.

Employee's Signature **Date**