

PREFERRED BLUE ACCOUNT

ELECTION FORM

NAME:	DATE OF BIRTH:	SOCIAL SECURITY:
STREET ADDRESS:	CITY, STATE, ZIP:	
EMPLOYER NAME:	GROUP NUMBER:	EFFECTIVE DATE:

I and my employer agree that my pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected under the Preferred Blue Account, and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for each benefit option is set forth below.

PREFERRED BLUE ACCOUNTS

Health FSA

<input type="checkbox"/> Yes <input type="checkbox"/> No	Deduction per pay period: _____ Payroll Frequency: _____ Annual Election Amount: _____
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Dependent Care Account

<input type="checkbox"/> Yes <input type="checkbox"/> No	Deduction per pay period: _____ Payroll Frequency: _____ Annual Election Amount: _____
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The terms of the Preferred Blue Accounts under the Section 125 Cafeteria Plan have been explained to me and I have read the descriptive material. I understand my options with regards to elections made under it. I hereby elect the benefits as indicated above and agree to have the pre-tax benefits purchased as an employer contribution on my behalf. I understand that by signing and submitting this enrollment form, that the benefits above will remain in effect for the entire plan year and that this election cannot be revoked or changed during the plan year, unless there is a change in family status (i.e., marriage, divorce, death of a spouse, birth or adoption of a child or termination of employment of a spouse).

EMPLOYEE'S SIGNATURE:	DATE:
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FOR REFUSAL ONLY

This plan has been explained to me and I choose not to participate this year.

EMPLOYEE'S SIGNATURE:	DATE:
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An Independent Licensee of the Blue Cross and Blue Shield Association.