

# 125 CAFETERIA ENROLLMENT FORM

City of Rexburg



CITY OF  
**REXBURG**  
America's Family Community

35 N 1<sup>ST</sup> E  
Rexburg, ID 83440

www.rexburg.org

Phone: 208.359.3020  
Fax: 208.359.3022

## SECTION 1: PERSONAL INFORMATION

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
FIRST LAST

PHONE # : \_\_\_\_\_ DOB: \_\_\_\_\_ DOH: \_\_\_\_\_

## SECTION 2: BENEFIT ELECTION

If you are part of the City health insurance plan, your premiums will automatically be paid pre-tax by payroll deduction. You may also choose any of the following benefits to add to your pre-tax deduction:

**HEALTH CARE EXPENSES (FLEX):**  Initial Request  New Year Request  Waive Participation  
\$ \_\_\_\_\_ Annual Election

**DEPENDENT CARE EXPENSES:**  Initial Request  New Year Request  Waive Participation  
\$ \_\_\_\_\_ Annual Election

I acknowledge the City of Rexburg has made me aware the following coverages are available at my own expense and will circle those items in which I elect participation. Otherwise, I will waive participation.

AFLAC CANCER  
AFLAC ACCIDENT  
COLONIAL CANCER  
COLONIAL GAP INS.

AFLAC HOSPITAL CONFINEMENT  
AFLAC SPECIFIED HEALTH EVENT  
COLONIAL HOSPITAL CONFINEMENT

AFLAC INTENSIVE CARE  
AFLAC PERSONAL SICKNESS  
COLONIAL CRITICAL ILLNESS

ELECT PARTICIPATION

WAIVE PARTICIPATION

## SECTION 3: DEBIT CARD (FLEX & HRA ONLY)

PLEASE RENEW  DO NOT HAVE CARD; PLEASE ISSUE  WAIVE CARD OPTION

There may be a fee associated with the use of the debit card. Contact HR for further information.

## SECTION 4: EMPLOYEE SIGNATURE

I hereby authorize the appropriate payroll reductions as my contribution(s) to the Cafeteria Plan until changed by me in writing. I recognize that such payroll reductions shall be adjusted automatically in the event of a change in the insurance premiums of the benefits I have selected. I will only use the Flexible Spending Account (including the use of a Debit Card) for eligible expenses under the plan, and I understand I will be responsible to pay for any transactions not allowed by the plan. In addition, I authorize the release of medical and account information to my spouse (if applicable).

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date