Excluded & Management / Supervisory
Flexible Benefits Enrollment / Election Form

Name _____ Last 4 Digits of SSN _____

Note: Changing your election from family to single or single to family coverage on this form does not change your payroll deduction. You must complete the applicable insurance forms to remove or add dependents to your insurance plans.

Amounts indicated on this form are Monthly Deductions.

Fill in Dollar Amount of Selected Options

1. Health Insurance:

_____ Wellmark Health Plan of Iowa - Single

_____ Wellmark Health Plan of Iowa - Family $ _____

2. Dental Insurance:

_____ Principal Dental - Single

_____ Principal Dental - Family $ _____

3. Vision Insurance:

_____ Avesis Vision - Single

_____ Avesis Vision - Family $ _____

4. Life Insurance:

__X__ $30,000 Basic Coverage $ 0.00

5. Flexible Spending Accounts:

_____ a. None $ 0.00

_____ b. Health and/or Dependent Flexible Spending Account
(Attach Separate FSA Enrollment Form, if applicable) $ _____

6. Cost of Pre-Tax Benefits (1+2+3+4+5) $ _____

7. Total Flexible Benefit Dollars $ - 184.00

8. Subtract Line #7 from Line #6 and enter amount
(Indicate Negative amounts in parenthesis)

If line #8 is less than line #7, this amount will be added to your gross taxable earnings.
If line #8 is greater than line #7, your gross taxable earnings will be reduced by this amount. $ _____

My signature on this form certifies that I have received and read the printed material explaining the Polk County Flexible Benefit Plan. I have indicated my benefits election above. I understand that I cannot change my Flexible Spending Account elections during a plan year unless my family status changes. If the total cost of my elections is less than my total Benefit Dollars, I understand that my remaining Benefit Dollars will be paid to me during each fiscal year semi-monthly. If the total cost of my elections exceeds my total Benefit Dollars, I authorize the Polk County Auditor's Office to redirect my pay by the amount of the difference. If the cost of my insurance benefits change during the plan year, I understand the cost of my pre-tax premium will be adjusted accordingly. I understand that this election shall remain in effect until I revoke or modify the election.

_____ _____

Employee Signature Date