SelectAccount℠

TAXSAVER HEALTH OPTION ENROLLMENT FORM

(I) EMPLOYER/EMPLOYEE INFORMATION

Employer Number: ______________________________ **Plan Year:** _______________ **through:** _________________

Employee Social Security Number: ________________________________

Employee Name: ____
(Last, First, MI)

Home Address: ____

______________________________, ______ __________ -__________
(City) (St) (Zip)

Daytime Phone Number: (__ __ __) __ __ __-__ __ __ __ **Date of Birth:** _______________

Email Address: ____

Location: ____

Effective Date: ________________________________ **(To Be Provided by Group Contact)**

(II) ELECTIONS

TaxSaver Health Options Account

☐ I want to contribute a total of $ _____________ during this Plan Year to my TaxSaver Health Options Account. I understand this amount will be deducted from my pay throughout the Plan Year.

I have reviewed the above election(s) and understand my choices will remain in effect for the entire Plan Year unless I experience a change in status as defined by the IRS. I understand that any individual health plan purchased by me and paid through payroll deduction is not sponsored or administrated through my employer. It is also my understanding that any funds remaining in my account(s) at the end of the Plan Year will be forfeited.

____ ______________________________
Signature Date

P.O. Box 64193 St. Paul, MN 55164-0193 Phone (651) 662-5065 / (800) 859-2144 Fax (651) 662-7247