

Employee Enrollment Form

Email to: Flex@hng.com
 Fax to: 866-600-7398 or 225-644-9985

Plan Year	Through	Agent Name	Agent Phone Number
Effective Date		Date of Hire	
Employer		Telephone	
Employee Last Name		First Name	MI
Address		Date of Birth	
City		State	Zip
E-Mail Address		Telephone	
Social Security Number: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Employee ID Number: _____	

- Medical Flexible Spending Account (FSA)**
- Health Reimbursement Arrangement (HRA)**
- Dependent Daycare (DCAP)**

I elect to participate and designate the following amount for my benefit(s) above:

\$ _____ **Monthly** **Quarterly** **Yearly**

Bank Name	<input type="checkbox"/>	Checking	OR	<input type="checkbox"/>	Savings
Routing Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	(First nine numbers on bottom left of your checks, starting with 0, 1, 2 or 3.)				
Account Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					

DEPENDENTS:

NAME	RELATIONSHIP	SOC. SEC. NO.	DATE OF BIRTH

I certify the above information to be correct and true to the best of my knowledge and that the children listed under "Dependent Coverage" either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment.

Signed _____ Date _____