

POLESTAR BENEFITS, INC. - EMPLOYEE ENROLLMENT FORM

SUBMIT FORMS TO: 412 Jefferson Parkway, Suite 202 - Lake Oswego, OR 97035 **OR Fax** (888) 539-9565 **OR Email** info@polestarbenefits.com

EMPLOYER		EFFECTIVE DATE		ENROLLMENT TYPE <input type="radio"/> Open Enrollment / New Hire <input type="radio"/> Add / Change Reason: _____			
EMPLOYEE INFORMATION							
LAST NAME		FIRST NAME		MI	SSN	DATE OF HIRE	DATE OF BIRTH
MAILING ADDRESS		APT	CITY		STATE	ZIP	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE
EMAIL ADDRESS (REQUIRED)				PHONE		ALT. PHONE	
DEPENDENT INFORMATION							
<i>Special Request: If a Benefit Card is offered, would you like an additional card for your spouse?</i> <input type="radio"/> YES <input type="radio"/> NO							
SPOUSE NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE	CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE
CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE	CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE
CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE	CHILD NAME		DOB	<input type="radio"/> ENROLL <input type="radio"/> WAIVE
SECTION 125 - FLEXIBLE (FSA), DEPENDENT CARE (DCA) SPENDING ACCOUNT, TRANSIT ACCOUNT & PREMIUM ONLY PLAN				DIRECT DEPOSIT AUTHORIZATION			
Flexible Spending Account Election			ACKNOWLEDGEMENT AND AUTHORIZATION: I hereby request coverage as outlined above under the Polestar Benefits, Inc. plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.***125/FSA and HRA Acknowledgement***The dependents for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for support. I am aware the premium and other contributions made under this plan are the property of my employer and will be used to purchase the elected coverage and cannot be refunded. Reimbursement account claims must be accompanied by proper documentation (i.e. a reimbursement request and related receipt(s) or Explanation of Benefits) of the out-of-pocket expense and be incurred within the plan year. This agreement cannot be revoked or changed, unless I experience a qualified change in status. WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud, which is a crime.				
PAY PERIOD ELECTION \$	# OF PAY PERIODS	ANNUAL ELECTION \$					
Dependent Care Account Election							
PAY PERIOD ELECTION \$	# OF PAY PERIODS	ANNUAL ELECTION \$					
Transit Spending Account Election							
PAY PERIOD ELECTION \$	# OF PAY PERIODS	MONTHLY ELECTION \$					
Premium Only Plan Election			BANK ACCOUNT INFORMATION <input type="radio"/> CHECKING <input type="radio"/> SAVINGS Routing # _____ Account # _____				
ENTER THE TOTAL AMOUNT PER MONTH	MONTHLY ELECTION \$	EMPLOYEE SIGNATURE					DATE
DECLINATION OF PARTICIPATION My Employer's Cafeteria Plan has been explained to me; I have been given the opportunity to participate and have elected not to do so in: <input type="radio"/> Flexible Spending Account <input type="radio"/> Dependent Care Account <input type="radio"/> Transit Account				<i>I have read and understand the statements above. I hereby authorize Polestar Benefits, Inc. to initiate direct deposits to the bank account listed above. It is my responsibility to notify Polestar Benefits, Inc of any changes relating to my account. I may cancel the direct deposit option at any time.</i>			
EMPLOYEE SIGNATURE		DATE					