Benefit Plan Participation Form

Employer: MSU Denver

Plan Year: 01 / 01 / 2020 to 12 / 31 / 2020

Initially enroll or annually re-enroll in the Cafeteria Plan

Plan Effective Date: 01 / 01 / 2020

Participant Data (All fields are required)

Employee Name: _____ SSN: _____
Last First M.I.

Address: _____
Street City State Zip

Email: _____ Phone: _____ Date of Birth: _____
mm/dd/yyyy

Initial Enrollment

I elect to reduce my compensation for each pay period during the plan year (or during such a portion of the year as remains after the date of this agreement) and redirect such dollars into the Benefit Plan as set forth below.

	Annual Election	Number of Pay Periods	Per Pay Period Deduction
☐ **Medical Flexible Spending Account**		12	
☐ **Dependent Care Spending Account**		12	

☐ **I want the 2020 Medical Flexible Spending IRS Maximum for the year**

☐ **I want the 2020 Dependent Care Flexible Spending IRS Maximum for the year**

Signature and Authorization

I hereby certify I have read and understand the Terms and Conditions of this Plan which appear at the link http://goo.gl/AXVASm and in the Summary Plan Description and agree to abide by said Terms and Conditions. If waiving participation, I hereby certify I fully understand the benefits available to me under this Cafeteria Plan.

_____ _____
Employee's Signature **Date**