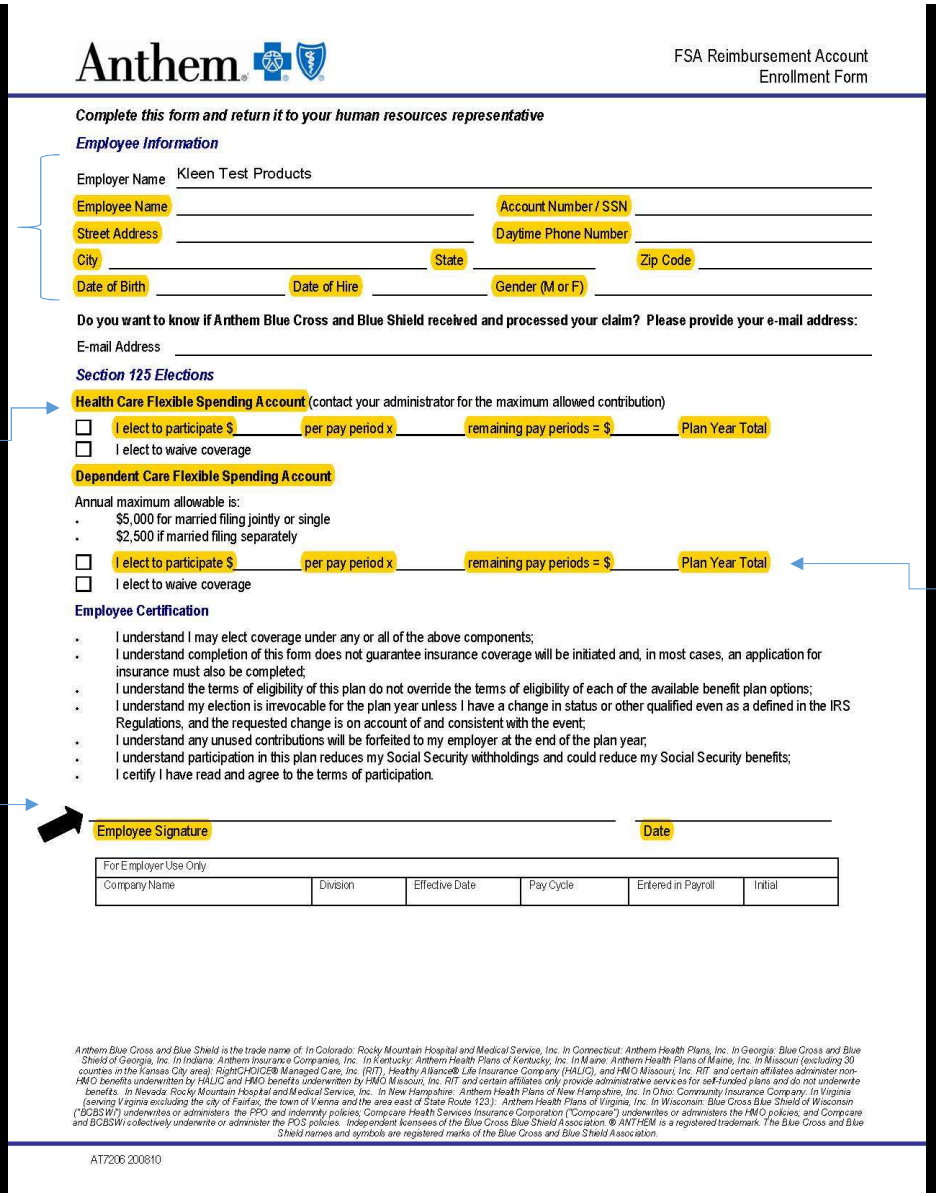
HOW TO ENROLL IN FLEXIBLE SPENDING?

*Complete the Employee Information section if you are enrolling in this plan.

**If you want to enroll the Health Care Flexible Spending Plan, mark your option. If you want to enroll, you need to write down how much you are wanting to put towards this account each pay period

*Sign & date the bottom



Anthem

FSA Reimbursement Account Enrollment Form

Complete this form and return it to your human resources representative

Employee Information

Employer Name: Kleen Test Products

Employee Name _____ Account Number / SSN _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ Zip Code _____

Date of Birth _____ Date of Hire _____ Gender (M or F) _____

Do you want to know if Anthem Blue Cross and Blue Shield received and processed your claim? Please provide your e-mail address:

E-mail Address _____

Section 125 Elections

Health Care Flexible Spending Account (contact your administrator for the maximum allowed contribution)

☐ I elect to participate $_____ per pay period x _____ remaining pay periods = $_____ Plan Year Total

☐ I elect to waive coverage

Dependent Care Flexible Spending Account

Annual maximum allowable is:

- $5,000 for married filing jointly or single
- $2,500 if married filing separately

☐ I elect to participate $_____ per pay period x _____ remaining pay periods = $_____ Plan Year Total

☐ I elect to waive coverage

Employee Certification

- I understand I may elect coverage under any or all of the above components;
- I understand completion of this form does not guarantee insurance coverage will be initiated and, in most cases, an application for insurance must also be completed;
- I understand the terms of eligibility of this plan do not override the terms of eligibility of each of the available benefit plan options;
- I understand my election is irrevocable for the plan year unless I have a change in status or other qualified even as a defined in the IRS Regulations, and the requested change is on account of and consistent with the event;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand participation in this plan reduces my Social Security withholdings and could reduce my Social Security benefits;
- I certify I have read and agree to the terms of participation.

Employee Signature _____ Date _____

For Employer Use Only					
Company Name	Division	Effective Date	Pay Cycle	Entered in Payroll	Initial

AT7206 200810

*If you want to enroll the Dependent Care Flexible Spending Plan, mark your option. If you want to enroll, you need to write down how much you are wanting to put towards this account each pay period