



Select Data Service Administrators, Inc.
 P.O. Box 2076
 Batesville, AR 72503
 Toll-free Fax: 1.888.877.4747



MEDICAL SPENDING PLAN ENROLLMENT FORM

(Please complete and sign form. Please PRINT clearly.)
 - Confidential -

Employer Name: _____ Worksite: _____

Employee Name: _____ Social Security No: _____ - _____ - _____

Complete Mailing Address: _____

Annual Election	Number of Deductions	Amount to be Deducted Per Pay Period	Effective Date
\$ _____	_____	\$ _____	_____

I hereby authorize and direct my employer to reduce my salary in the amount listed above under the Flexible Benefits Program.

As a participant in the Medical Spending Plan, I am entitled to revoke my elected benefit election in the event of certain changes in family status that are permitted as described and stated in the Plan Summary Plan Description.

A new election is required for each and every Plan Year.

I understand that the change in my benefit must be necessitated by and consistent with the change in family status and the change must be acceptable as described and stated in the Plan Summary Plan Description.

(Initials)

I Decline To Participate In The Medical Spending Plan

 Signature

 Date