ROCKY MOUNTAIN reserve

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Cafeteria Plan Enrollment Form

Employer: Delta Solutions & Strategies, LLC

Plan Year: **20** 2 3 **or** __/__/__ **to** __/__/__

This Enrollment Form is being used to: ***(Check one)***

- ☒ Initially enroll or annually re-enroll in the Cafeteria Plan
- ☐ Waive participation in the Cafeteria Plan

Participant Information

***Required fields**

Employee Name* _____ **SSN*** _____

Last *First* *M.I.*

Address* _____

Street *City* *State* *Zip*

E-mail Address* _____ **DOB*** _____

mm/dd/yyyy

Phone Number (Required for HSA Accounts)* _____

Enrollment Information

I elect to reduce my compensation for each pay period during the plan year and redirect such dollars into the Cafeteria Plan as set forth below.

	Contributions Per Pay Period	Number of Pay Periods	Annual Election
☐ **Health Care FSA**			
☐ **Dependent Care FSA**			
☐ **Limited Purpose FSA (Dental & Vision)**			
☐ **Health Savings Account (HSA)**			

☐ **Debit Card**
I understand that I will automatically receive a debit card with my enrollment in the FSA plan and I would like to order a card for my spouse or dependent.

Spouse or Dependent Name SSN Birth Date

_____

Signature and Authorization

I understand that an FSA election is made before a year begins and cannot be changed until the next year unless I experience a change of status I agree to notify the Company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand, for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax on any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I agree to follow the terms and conditions set forth in the Summary Plan Description. The Plan Administrator may reduce my compensation reduction or otherwise modify this agreement in the event it is believed to be advisable in order to satisfy provisions of the Internal Revenue Code. My Social Security benefits may be slightly reduced as a result of my election. This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Company.

I understand the eligibility requirements for deposits made to my Health Savings Account (HSA) and state that I qualify to make deposits to this account. I assume complete responsibility for determining my eligibility for an HSA each year I make a contribution, ensure all contributions made to my account are within the limits set forth y the tax laws, and any tax consequences of contributions (including rollover contributions) and distributions. If my employment is terminated I agree to contact Rocky Mountain Reserve regarding my account.

Employee Signature _____ **Date** _____