Regence Personal Choice Account

Enrollment Authorization and Agreement for Company Code/Company Name
Plan Year: From Start Date To End Date

Employee Name ______________________ SSN (Required) ______________________
Address ____
City ______________________ State ______________ Zip ______________
Work Location ______________________ Work Phone (_______) ______________________

I authorize Group Name to withhold a portion of my pre-tax employment compensation and deposit these funds into my elected Regence Personal Choice Account spending programs as listed below:

Employee Insurance Premium Contribution
(Adjusted automatically to reflect group rate changes.) $_______Per pay-period x _____ # of pay-periods = _____Annual Election

Health Care Spending Account $_______Per pay-period x _____ # of pay-periods = _____Annual Election

Dependent Care Spending Account $_______Per pay-period x _____ # of pay-periods = _____Annual Election
(Cannot exceed the lower of husband's or wife's earned income. $5,000 annual maximum if head of household or married filing jointly; $2,500 annual maximum if married filing separately)

In Consideration of Group Name allowing me to participate in its Regence Personal Choice Account (Regence PCA), I acknowledge and agree as follows:

Accept Regence PCA Plan Terms: I agree to abide by the terms, conditions and provisions of the Regence PCA contained in Group Name's Plan Document, I acknowledge my right to examine the Plan Document or obtain a copy of it by giving reasonable advance notice to the plan administrator and paying a reasonable copy cost.

Responsibility: I acknowledge that the Internal Revenue Code and Regence PCA permit me to claim reimbursement only for my tax deductible expenses incurred after the effective date of my Regence PCA elections and I assume full responsibility for all taxes, penalties, interest or other consequences which may be assessed to me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursements from Regence PCA for disallowed expenses.

Dependent Care: I understand that the Internal Revenue Code prohibits me from claiming the Federal Child Care Tax Credit for dependent care assistance expenses which are reimbursed to me by Regence PCA.

Plan Modification: I have been informed that the Regence PCA offered by Group Name may be modified from time to time and I agree that Group Name may cancel or amend the Regence PCA according to their independent judgments and discretion without my consent or prior notice to me.

Social Security: I choose to participate in Regence PCA despite my knowledge that my salary reduction elections may reduce my FICA withholdings (Social Security) and that this may reduce my Social Security benefits upon retirement.

Forfeiture: I understand that I must claim reimbursement for eligible expenses incurred during the plan year on or before 90 days after the last day of the plan year or I will forfeit those reimbursements. I further acknowledge that I will forfeit all funds credited to my Regence PCA accounts which are not reimbursed to me.

Seek Advice: I have been informed that my participation in Regence PCA will have tax and economic consequences to me and that before deciding to participate in Regence PCA I may wish to seek professional advice regarding the benefits, risks and limitations of Regence PCA.

______________________________ ______________________________
Employee's Signature **Date**

Waiver of Participation: By my signature here ______________________, I acknowledge that the Regence Personal Choice Account has been offered to me and I elect to not participate.

Employer HR Use Only:

Employee's **Effective Date of Coverage:** ______________

Employee's **First Payroll Date:** ______________

FOR YOUR HEALTH