

Enrollment Form

Employee Benefits Corporation

■ Submit completed form to your Employer.

Clark County		
rganization Name	Department	
Participant Information (Please print)		
Tadapant Inomiator (Hease ping		
ast Name	Suffix First Name	M
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ender Date of Birth (mm-dd-yyyy)	Date of Hire (mm-dd-yyyy) Participant Social Security or Identification number	_
lailing Address	Apt. No. City State Zip Code	
ome Phone 123-456-7890 E-mail Ad	dress (we do not share your e-mail address)	
Plan Dates (refer to "My Company Plan" Eligibility section)		
That Dates feld to my company than Englishing seedony	Effective Start Date (mm-dd-yyyy) Number of Pay Periods	
Plan Benefits: I elect to have Elections below deducted from r	ny pay tax-free and placed into the following accounts	
	Employee Election	
	portay raisa inter	
tandard Health Care FSA \$		
imburses all digible medical expenses; not for use with HSA		
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