

**Health Care & Dependent Day Care
Reimbursement Accounts
Enrollment**



EMPLOYEE INFORMATION			
BNL LIFE #	BNL BLDG #	PAYROLL FREQUENCY: (check one) <input type="checkbox"/> MONTHLY <input type="checkbox"/> WEEKLY	
SOCIAL SECURITY NUMBER	COMPANY NAME BROOKHAVEN SCIENCE ASSOCIATES	ACCOUNT NUMBER 2258277	
LAST NAME		FIRST NAME	M.I.
STREET ADDRESS			
CITY		STATE	ZIP CODE
PRE-TAX REIMBURSEMENT ACCOUNTS			
HEALTH CARE REIMBURSEMENT ACCOUNT		ANNUAL AMOUNT ELECTED: \$ _____ NOT a pay period	
DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT		ANNUAL AMOUNT ELECTED: \$ _____ NOT a pay period	
<i>ANNUAL AMOUNT ELECTED will be divided by the number of pay periods in the Plan Year.</i>			
AUTHORIZATION			
<p>I hereby authorize my employer to reduce my earnings by the amount(s) stated above for deposit into my Health and/or Dependent Day Care Reimbursement Account and to make this money available to me for the reimbursement of Health and/or Dependent Day Care out-of-pocket expenses as appropriate.</p> <p>I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY THE INTERNAL REVENUE CODE SECTION 125.</p>			
SIGNATURE		DATE	

FOR EMPLOYER USE ONLY		
EFFECTIVE DATE (REQUIRED)	DIVISION NAME Not Applicable	DIVISION NUMBER Not Applicable