**ABC Company Ltd.**

**Benefits Enrollment Form**

Employee Information:

**Employee Name:** EmpName

**Employee ID:** EmpId

**Department/Division:** Dept

**Position/Title:** Pos

**Date of Hire:** DtJoin

Benefits Enrollment Period: Dt till Resignation Date

**Medical Insurance:**

- [ ] Medical Plan A

- [ ] Medical Plan B

- [ ] Medical Plan C

**Retirement Plans:**

- [ ] 401(k) Plan

- [ ] Roth IRA

- [ ] Pension Plan

**Additional Benefits:**

- [ ] Flexible Spending Account (FSA)

- [ ] Health Savings Account (HSA)

- [ ] Life Insurance

- [ ] Disability Insurance

**Beneficiary Information (if applicable):**

- Name:

- Relationship:

- Percentage Allocation:

**Acknowledgment:**

I, EmpName , have reviewed the available benefits and hereby make my selections for the upcoming benefits period. I understand that my choices are binding for the duration of the benefits period, and changes may only be made during the next open enrollment period or in the case of a qualifying life event.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Use Only:

- Date Form Received:

- Processed by: HR\_Name

For any questions or clarification regarding benefits enrollment, please contact the Human Resources Department at [**pranavsundar08@outlook.com**](mailto:pranavsundar08@outlook.com).