



**Yes, I want to save tax dollars!**

I understand that my Social Security benefits may be affected by my participation in this plan. I also understand that, to provide services to my employer in connection with one or more employee benefit plans maintained by my employer, **DELPHI CARD** may need protected health information regarding coverage or benefits for me or my dependents under the plan. By signing this enrollment form, I hereby irrevocably authorize **DELPHI CARD** to obtain and use such information and disclose it to my employer (or to an insurer or other provider of services to the plan), but only for purposes of the plan and only for as long as **DELPHI CARD** is providing services regarding the plan. Any information disclosed pursuant to this authorization will not be subject to re-disclosure by the recipient, except for purposes of the plan. I understand that my enrollment can be denied if I do not sign this form.

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**Signature**

**Date**

**No, I do not want to participate.**

I understand that I have been given the opportunity to enroll in the **DELPHI CARD** Plan with my employer on this date. I have elected not to do so in this plan year. I also understand that if there is a qualifying event, I may have a right to sign on to the plan at that time.

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**Signature**

**Date**

**DELPHI CARD** [www.delphicard.com](http://www.delphicard.com)

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