

BENEFIT ELECTION FORM

COMPANY NAME

EMPLOYEE NAME

HIRE DATE

BENEFIT EFFECTIVE DATE

Please indicate which benefits you wish to elect or waive by marking an "X" in the appropriate space. Please mark on EACH area – do not leave any blank.

	Enrolling	Waiving
Medical	_____	_____
Dental	_____	_____
Section 125 Flexible Benefit Plan	_____	_____

If I am waiving any of the benefits, I understand that the next opportunity to enroll will be open enrollment of the following year. I also understand that if I have a life event change (i.e. marriage, divorce, birth/adoption of a child, COBRA expiration), I will be able to enroll at that time. Employer must be notified within 30 days of the qualifying event.

Pre-tax Premium Pay Plan

I will participate in the Pre-tax Premium Pay Plan so as to be able to pay my health, dental, and Sec. 125 Benefit Plan insurance premiums using pre-tax dollars. The program has been explained to me and I understand that if I elect to participate I am making a binding election to reduce my paychecks by the dollar amount necessary to pay my portion of the premiums charged to cover me, my spouse (if any), and dependents (if any).

I hereby authorize my employer to reduce my paychecks to pro rata throughout the year by the amount necessary to pay such premiums. I understand that my election will remain in place for the plan year and I cannot increase, decrease, or suspend the salary reductions to be made hereunder except in connection with a qualifying life event change.

Employee Signature

Date