

Benefit Election Form and Salary Reduction Agreement

Employers Name: _____

Employee Name (Last, First, MI) _____

Social Security No. _____

Employee Street Address _____

City, State, Zip Code _____

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown under the Premium Conversion and Reimbursement Accounts headings shown below and to deduct from after-tax income the post-tax items shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date the Plan. I further authorize future adjustments in the amount of the salary reduction in the even the cost of coverage in any problem selected below under the heading PREMIUM CONVERSION is changed by the carrier during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction or after-tax deduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit (All amounts paid should be per deduction period)	<u>Salary Reduction per Pay Period</u>
Premium Conversion (Group Health; Employer provided only)	
Medical	\$ _____
Dental	\$ _____
Vision	\$ _____
Cancer	\$ _____
Pretax Deduction for Insurance Premiums	\$ _____
Reimbursement Accounts	
FSA Medical Expenses (Reimbursed)	\$ _____
FSA Dependent Care; Day Care (Reimbursed)	\$ _____
PPP (Personal Policy Plan) (Individually Owned Health Policy)	\$ _____
Pretax Deduction for Reimbursement Accounts	\$ _____
Total Deductions for both Premium and Reimbursed	
.....	\$ _____
Effective date: _____	Effective on Pay Period: _____

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status.

To Authorize Participation: I hereby certify the above information to be correct and true and choose *to participate*.

Signature _____

Date _____

Decline Participation: I hereby *decline* participation in the 125 Cafeteria Plan

Signature _____

Date _____

Shaffer Insurance Services Inc., Benefits Division
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