Benefit Election Form and Salary Reduction Agreement

EMPLOYER ____
Employee Name (Last, First, MI) ____
Social Security No. ____
Employee Street Address ____
City, State, Zip Code ____
Email address required ____

I hereby authorize and direct my employer to reduce my salary by pay period in the amount specified to pay for the coverage's under the Premium Conversion and Reimbursement Accounts headings shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date of the plan. I further authorize future adjustments in the amount of the salary reduction in the event that the cost of coverage in any program selected below under the heading PREMIUM 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 reduction per pay period cost. These selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Salary Reduction Amount Per Pay Period

Premiums (Health Insurance/Employer Provided)
(Such as: Blue Cross, Health Net, Kaiser, Delta Dental)
Medical, Dental, Vision, Cancer, Other $___________
Per pay period Pretax Deduction $___________
Reimbursement Accounts Reimbursement Accounts
FSA Medical Expenses .... $____________
FSA Child Care .... $____________
Per pay period Pretax Deduction for Reimbursement Accounts $____________
Total Deductions per pay period .... $____________
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______________________

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose not to participate **not to participate**.
Signature____ Date_____________________

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