

# PREMIUM PAYMENT PLAN ENROLLMENT FORM

(Please complete and sign form. Please PRINT clearly.)

- Confidential -

Employer Name: \_\_\_\_\_ Worksite: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Number of Deductions: \_\_\_\_\_ Date of First Deduction: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Premium Rate Per Pay Period:

Medical \$ \_\_\_\_\_ Life \$ \_\_\_\_\_ Accident \$ \_\_\_\_\_

Dental \$ \_\_\_\_\_ ICU/CCU \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

Cancer \$ \_\_\_\_\_ Heart/Stroke \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

I hereby authorize and direct my employer to reduce my salary in the amount listed above under the Section 125 Program.

As a participant in the Premium Plan, I am entitled to revoke my elected benefit election in the event of certain changes in family status that are permitted as described and stated in the Plan Summary Plan Description.

Unless I notify my Employer, this election will automatically continue for each subsequent Plan Year.

My Social Security benefits may be slightly reduced as a result of my election.

I understand that the change in my benefit must be necessitated by and consistent with the change in family status and the change must be acceptable as described and stated in the Plan Summary Plan Description.

(Initials)

I Decline To Participate In The Premium Payment Plan

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date