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