PREMIUM ONLY ENROLLMENT FORM

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Please print clearly

EMPLOYER:	DIVISION:		
SSN:	□ OPEN ENROLLMENT □ NEW HIRE □ CHANGE* EFFECTIVE DATE (mm/dd/yy):		
NAME:	BIRTH DATE (mm/dd/yyyy):		
MAILING ADDRESS:	PHONE:	□ M □ F	□ Married □ Single
CITY: STATE: ZIP:	EMAIL:		

FLEXIBLE BENEFITS ELECTION AUTHORIZATION

PLAN / ACCOUNT TYPE	PREMIUM AMOUNT	PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		TOTAL ANNUAL ELECTION
GROUP INSURANCE	_____	_____	x	_____	=	_____
_____	_____	_____	x	_____	=	_____
_____	_____	_____	x	_____	=	_____
_____	_____	_____	x	_____	=	_____
_____	_____	_____	x	_____	=	_____

CERTIFICATION ***I certify that these are my benefit elections and that*** **:**

1. I authorize the "before-tax" deduction of a portion of my pay based on the elections above.
2. I understand that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in status.
3. I understand that my unused premium contributions cannot be refunded to me and become the property of my employer.
4. I understand that this agreement will continue from year to year unless revoked, in writing, during open enrollment.

Both an employee signature and company authorization are required for enrollment to be completed.

Signed: _____ Date: _____

Company Authorization: _____ Date: _____

***If this is an election change, please indicate the qualifying event:**

_____ HR initials _____