ENROLLMENT ELECTION FORM 2023

Employer Name: _____Deduction Start Date ____/____/____ Plan Start Date: ___/___/____

Employee Name: _____ SSN: _____ DOB: _____ /_____ /_____

Home Address: _____ City: _____ ST: _____ Zip: _____

Email: _____

Home #: _____ Work #: _____Hire Date / / DEPT: _____

Pre- Tax Deductions	**Carrier Name**	***Electing Coverage**		**Carrier Name**	***Cancelling Coverage**
Accident					
Cancer					
Dental					
Vision					
Total Deductions Monthly		$			$

- Payroll Mode is figured Monthly

After - Tax Deductions	**Carrier Name**	***Electing Coverage**		**Carrier Name**	***Cancelling Coverage**
Life					
Life					
Short Term Disability					
Total Deductions Monthly		$			$

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage shown above. Such reductions, considered as elective contributions under the plan, shall commence with my paycheck-dated ___/___/___. I further authorize future adjustment in the amount of the salary reduction in the event that the cost of coverage in any program selected is changed 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 above are the benefits I have selected under the plan. The total cost per pay period and the amount to be paid by salary reduction are indicated on this form. The selection will remain in effect until a subsequent election form is filed, in accordance with the plan. I have read and agree to the additional terms listed below.

Initial Here

*_____ **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 (e.g. marriage, divorce, death of a spouse or child, birth or adoption of a child, and termination of employment of spouse.)

*_____ I understand that insurance claim payment(s) under certain coverage(s) May be subject to federal taxes when the premium is paid by salary reduction.

_____ I authorize the payroll department to discontinue the payroll deduction of the above listed premiums under the **Discontinue** column. I understand if I choose to I may continue the coverage's on my own but they will no longer be payroll deducted.

AUTHORIZATION PLEASE SIGN:	**DECLINE PARTICIPATION:**
I certify the above information to be correct and true. **Signature**_____ **Date**_____	The benefits of the plan have been thoroughly explained to me and I decline to participate. I understand I may not participate until next year. **PLEASE CHECK & INITIAL ☐ ____**