

**Employee Benefits Election/Change Form**  
*For pre-tax deductions*

Name: \_\_\_\_\_

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Hire Date: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Reason for Election:  Open Enrollment  New Hire

Mid-Year Plan Change:      Type of qualifying life event \_\_\_\_\_  
 Date of qualifying life event \_\_\_\_\_

The Company and I hereby agree that my gross pay will be redirected by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

**Employee's Flexible Benefit *Per Pay* Deduction/Allocation**

	Bi-Weekly Deduction	If deduction equals zero, indicate either: <i>Company Paid, Waive OR N/A</i>
Health Benefits Premium	\$	
Dental Benefits Premium	\$	
Vision Benefits Premium	\$	

**Salary Redirection Agreement**

I have read and understand the explanation I have received regarding my options under the Company's Health Care Plan. I understand I have the right to have the Company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the health insurance coverage I have designated above. I understand that the amounts above may be adjusted at open enrollment to reflect the change in rates charged by the carriers or the employee contribution approved by the Company. I acknowledge that my election is irrevocable unless there is a change in my family status or an open enrollment. A change in family status includes marriage; divorce; death of a spouse or dependent; birth or adoption of a child; or a change in my, or my spouse's, employment status.

I hereby apply for the options listed above. If necessary, I authorize \_\_\_\_\_ (location name) to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force for the Plan Year, unless my family status changes or I am eligible for an open enrollment.

**Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your coverage ends.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage provided under a Medicaid plan or under a state children's health insurance program, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your coverage ends.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days from the date you or your dependent are determined to be eligible for such assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

**Employee Signature**

**Date**

This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).