ENROLLMENT FORM FOR _____

Employer Name:

_____

Participant Name: _____ SS #: _____-_____

- ☐ Open Enrollment
- ☐ New Hire (Hire Date: ____/____/____)
- ☐ Key Employee (Officer or Owner)
- ☐ Change in Status

I elect to participate in (the amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer. This amount will be changed as necessary, if the premium changed by the insurance company changes.)

- ☐ Group Health Insurance
- ☐ Group Dental Insurance
- ☐ Group Vision Insurance
- ☐ Disability Insurance
- ☐ Group Life Insurance
- ☐ Others----------
- ☐ **I declined to participate**

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by sum of my premium contributions to the plan, such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year, unless there is a change in my status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and change of employment of spouse) which justifies the revocation or change. I have examined this agreement and to the best of my knowledge, it is true, correct and complete

Employee Signature _____ Date _____