



Election Form to Participate in Section 125 Premium Only Plan

Employer Name:	
Employee Name:	
Employee Social Security Number:	
Employee Address:	

I wish to participate in the POP for the following lines of Insurance:

- | | | |
|---|--|--|
| <input type="checkbox"/> Group Health Insurance | <input type="checkbox"/> Group Term Life Insurance | <input type="checkbox"/> Employer Vision |
| <input type="checkbox"/> Health Savings Account Contributions | <input type="checkbox"/> Employer Dental | <input type="checkbox"/> Others |
| <input type="checkbox"/> Disability Plans | | |

However, if disability premiums are paid pre-tax, benefits received are subject to taxation. Therefore, it is typically preferential to apply taxes to the premiums.

By checking any of the above boxes, your portion of the items listed above will automatically carry over from year to year until and unless you notify the Plan Administrator by completing another election form declining participation in the POP. Any changes will be effective as of the first day of the next plan year. The salary reduction amounts for the carry-over election will be adjusted automatically to reflect any increase or decrease in the cost of premiums. This "evergreen" election applies to any line of insurance selected above.

To decline POP coverage, please check the box below:

- I have been given the opportunity to enroll and pay my responsibility of the group sponsored premiums with pre-tax dollars and wish to decline participation of the Premium Only Plan until further written notice or qualifying event.

Change In Status - I have incurred the following change in status and am now eligible for the POP plan and to pay the above checked premiums with pre-tax dollars:

- | | |
|---|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Birth, adoption or placement for adoption of a child |
| <input type="checkbox"/> Divorce, legal separation or annulment | <input type="checkbox"/> Death of my spouse and or dependent |
| <input type="checkbox"/> Termination or commencement of employment by my spouse or dependent | |
| <input type="checkbox"/> Switching from part-time to full-time (or vice-versa) employment on the part of me or my spouse, or dependent or reduction or increase in hours, strike or lockout | |
| <input type="checkbox"/> I, my spouse or dependent have taken an unpaid leave of absence | |
| <input type="checkbox"/> A change in the residence or worksite of myself, my spouse or dependent | |
| <input type="checkbox"/> My dependent satisfies or ceases to satisfy the requirements for coverage | |
| <input type="checkbox"/> Other: _____ | |

Employee Signature _____

Date _____

Plan Year/Termination:

Any amounts remaining in your account at the end of the plan year will be forfeited after all premiums are paid. In addition, any balance remaining in your account on the date you terminate employment with the company will be forfeited after all premiums are paid.