Flexible Benefits Plan
Elective Contributions Form

_____
Employer Name

_____
Employee Name Social Security Number

_____
Employee Street Address City State Zip

Please complete all the above information for all plan participants.

Married_____ Male_____ Number of Pay Periods
Single _____ Female_____ Per Year_____

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage's shown below. 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 below 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.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per-deduction-period cost and the amount to be paid by salary reduction.
The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit* (All amounts should be per deduction Period.) Coverage	**Salary Reduction Amount Per Pay Period**
Medical	_____
Dental	_____
Term Life	_____
Cancer	_____
Disability (Short Term)	_____
Accidental Death and Dismemberment	_____
Vision	_____
Disability (Long Term)	_____
Other_____	_____
Totals	_____

*I understand that only benefits listed in my employer's Flexible Benefits Plan document are available. 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.

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 spouse or child, birth or adoption of a child, and termination of employment of spouse.)

Premiums for disability insurance will not be deducted pre-tax.

Signature_____ Date_____

IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline to participate.
Signature_____ Date_____