

SECTION 125 / BENEFIT ELECTION FORM

Name: _____ SS #: _____

Employer: _____ For the Plan Year: _____ to _____

I Elect to participate in the Section 125 Plan

I decline to participate in the Section

Provider/Benefit	Pre-Tax	After-Tax	Total
Medical _____	_____	_____	_____
Disability _____	_____	_____	_____
Dental _____	_____	_____	_____
Cancer _____	_____	_____	_____
Life _____	_____	_____	_____
Administration Fee _____	_____	_____	_____

CHANGES AND CANCELLATIONS

1. _____ 2. _____ 3. _____ 4. _____

With regard to my salary redirection agreement and my election of benefits, I understand that:

- I may not change elections during the plan year unless there is a change in my family status (i.e. marriage, divorce, death of my spouse or child, adoption or birth of my child in job status of myself/spouse/dependent (full/part-time, termination/beginning of employment), change in my spouse's/dependent's insurance coverage, a significant change in premiums, my dependent no longer eligible for insurance coverage, a legal separation/annulment.)
 I UNDERSTAND THAT I HAVE 30 DAYS FROM THE DATE OF ONE OF THE ABOVE OCCURRENCES TO MAKE A CHANGE IN MY PLAN.
- I understand that these elections do not constitute an enrollment for any of the insurance coverage listed nor does the cafeteria plan dates listed have any correlations to the effective date of insurance coverage.
- The administrator is authorized to adjust the amount of my salary redirection's and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
- Any amounts that are not used during a Plan Year to provide benefits will be forfeited any may not be paid to me in cash or used to provide benefits in a later Plan Year.
- I hereby release my employer, its officers, agents, and employees, from any legal liability or obligation for any cause or reason in connection with the Plan, except for willful misconduct or gross negligence.
- My election or salary redirection's and benefits remains in effect for later Plan Years unless I file a new election during the election period for such later Plan Years. This includes the medical or dependent care reimbursement accounts.

Signature: _____ Date: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Home Ph.: (____) _____ Work Ph.: (____) _____

E-mail: _____ Conference Time: _____ Campus: _____