PREMIUM ONLY PLAN
ENROLLMENT FORM

ELECTION AND COMPENSATION REDUCTION AGREEMENT

Company Name: ____

Employee Name: ____

Employee Social Security Number: ____

Employee Address: ____

Employee Email Address: ____

Plan Year: ___________________________

In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected for the plan year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each pay period and plan year (or during such portion of the year as remains after the date of this agreement).

ELECTION FOR INSURED BENEFITS

On the appropriate benefit enrollment form(s) of any insurance company, I have enrolled for certain insurance coverage.

☐ I elect to receive the following coverage under the Cafeteria Plan:

	COVERAGE	PREMIUM PER __________________
___	Dental coverage	$ ____
___	Health insurance coverage	$ ____
___	Vision insurance coverage	$ ____

☐ In lieu of specified dollar amounts, I hereby elect the above specified insurance coverage and authorize salary redirections in the amounts of current premiums being charged by each insurance company.

I understand that if my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease.

OTHER TERMS AND CONDITIONS

I understand that:

-- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the plan year unless I have a change in status and my election is consistent with such change.

-- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

-- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

-- Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later plan year.

-- If I select to be covered under the disability insurance through the Plan, then any benefits paid to me from such insurance will be fully taxable to me and that it will be my responsibility to include these amounts in my gross income.

-- My social security benefits may be slightly reduced as a result of my election.

-- Prior to the first day of each plan year, I will be offered the opportunity to change my benefit elections for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit coverage and amount of compensation reduction then in effect for the new plan year for insurance benefits only. For all other benefits, I will be deemed not to have elected any other benefits for this plan year.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.

____ ______________________
Employee's signature Date

Accepted and agreed to by the Employer's Authorized Representative-

____ ______________________
Authorized Representative signature Date