Section 125 Premium Only Plan
SALARY REDUCTION AGREEMENT

[ ] **Initial Election**	[ ] **Continuation of Election**	[ ] **Change of Family Status**	**Effective Date**

Employee's Name (Last, First MI)	**Social Security # (last four digits)** 0 0 0 ___ 0 0 ___ (___ ___ ___ ___)

Address (Street, City, State, Zip)

(area code) & Home Phone #	**Payroll Frequency**		Date Employed			Date of Birth		
	Weekly [ ]	Semi Monthly [ ]	Mo.	Day	Year	Mo.	Day	Year
	Bi-weekly [ ]	Monthly [ ]						

Medical Coverage		Dental Coverage		Vision Coverage	
EE Only [ ]	EE&Child [ ]	EE Only [ ]	EE&Child [ ]	EE Only [ ]	EE&Child [ ]
EE&Spouse [ ]	EE&Family [ ]	EE&Spouse [ ]	EE&Family [ ]	EE&Spouse [ ]	EE&Family [ ]

I hereby request that my pay be reduced per pay period as shown OR as billed during the plan year for:

	Insurance premiums		**Insurance premiums**
Medical Plan	$ ______ /pp	**Vision Plan**	$ ______ /pp
Dental Plan	$ ______ /pp		
HSA Plan	$ ______ /pp	**Total Cafeteria**	$ ______ /pp

Total to be withheld each pay period pre tax

Authorization To Participate In Salary Reduction Agreement:

I have read and understand the explanation I have received regarding my options under the Section 125 Premium Only Plan. I understand I have the right to have the company redirect my salary on a pre-tax basis during the plan year and apply this amount toward the purchase of group insurance coverage I have designated above. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; a change in worksite; or any change in employment status that affects eligibility; a change in residence for me, my spouse or children; or my dependent either satisfies or ceases to satisfy requirements for coverage due to change in age or any similar circumstances; or a change in my or my spouse's employment status. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

I hereby apply for the options listed above. If necessary, I authorize my employer to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force for the balance of the benefit year, unless my family status changes.

X ______________________   ______________________   X ______________________

Signature   Date   Company Representative

SIGN HERE ONLY IF YOU DECLINE TO PARTICIPATE IN THE CAFETERIA PORTION OF THE PLAN.
Signing here will require you to pay your premiums with after tax dollars which would increase your after tax cost.

______________________   ______________________   ______________________

Signature   Date   Witness