✓ ONE

ELIGIBILITY DATE ______/______/______ AS (✓ ONE):

☐ NEW EMPLOYEE

☐ MID-PLAN YEAR FAMILY STATUS CHANGE

JULY 1, 2005 TO JUNE 30, 2006

EMPLOYEE BENEFITS PLAN YEAR

ABC CLIENT, INC

Section 125/Cafeteria Plan Eligible Employee Benefit(s) Enrollment Summary

________________________ EMPLOYEE NAME

______-______-________ SSN

(____)_____-________ HOME PHONE NUMBER

________________________ WORK-SITE LOCATION/DEPARTMENT

________________________ EMPLOYEE JOB TITLE/CLASS

PAYROLL DEDUC FREQUENCY:

☐ (52 CHECKS YR) WEEKLY

☐ (26 CHECKS YR) EVERY 2 WEEKS

☐ (24 CHECKS YR) TWICE MONTHLY

☐ (12 CHECKS YR) MONTHLY

☐ *Initial here to request "NO CHANGES" to previous benefit elections*[1]

[2]Coverage Requested	ACTION: ADD/NEW; CHANGE; CANCEL	PROVIDER	BENEFIT(S) AVAILABLE	COVERAGE STATUS AVAILABLE (CIRCLE COVERAGE REQUESTED)	EMPLOYEE PRE-TAX DEDUCTION	EMPLOYEE TAXABLE DEDUCTION[3]
☐		Coventry	HMO 20/40/$500 Group Health	EE EE+CH(ren) EE+SP FAM	$	$
☐		Coventry	HMO 20/40/$500/100%/70% Group Health	EE EE+CH(ren) EE+SP FAM	$	$
☐		Coventry	Consumer Choice	EE EE+CH(ren) EE+SP FAM	$	$
☐		Ameritas	Indemnity Dental	EE EE+CH(ren) EE+SP FAM	$	$
☐		Jefferson Pilot	**Employee** Term Life	$________K LIFE $________K AD&D	Not Applicable	$
☐		Jefferson Pilot	**CH(ren)** Term Life	$________K LIFE	Not Applicable	$
☐		Jefferson Pilot	**Spouse** Term Life	$________K LIFE $________K AD&D	Not Applicable	$
				TOTAL DEDUCTIONS PER PAY CYCLE:	$________	$________

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge and have chosen to participate the benefit(s), as listed above. I understand that the deduction(s) and any benefits elected and *approved* will be in effect for the plan year and cannot be revoked or changed, unless I experience an "Family Status Change Event;" any request to change my elections, due to a Family Status Change Event, must be consistent with the event. I further understand it is my responsibility to notify the applicable parties, *in writing, within 30 days*, should I experience a verifiable Family Status Change event and wish to request a change in my coverage status or elections.

________________________ SIGNED TO PARTICIPATE

________________ DATED

DECLINATION OF PARTICIPATION: I have been given the opportunity to participate in all of the benefit(s) offered (as listed above) and have elected not to do so. I also understand that I my opportunity to request coverage may be declined or delayed until the next plan year's open enrollment, unless I experience a verifiable Family Status Change Event and request, *in writing, within 30 days*, to change my coverage status.

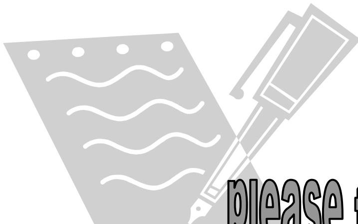
________________________ SIGNED TO DECLINE PARTICIPATION

________________ DATED

Please see reverse side

For general questions or claims issues regarding the benefits offered by ABC CLIENT, INC, please call our Broker, GROUP ACCESS, @ 770-692-0020.

Group Access



please take note:

[1] Although you may not make any election changes, your deductions may change based on age and/or premium increases, as applicable.
[2] This plan is administered and sponsored by your employer. A Section 125/Cafeteria Plan Eligible Employee Benefit(s) Enrollment Summary form provides a summary of all of the insurance/fringe benefits you have available to you; 401(K)/Retirement Salary Deferrals, if applicable, should be made on a separate form. Application(s) and/or change forms for each corresponding benefit must be submitted, on or before the applied for effective date, to ensure an employee's opportunity to request coverage or a change in coverage status. All requests for coverage for voluntary benefits, such as life and disability benefits will be submitted to underwriting *for approval.*
[3] YOUR EMPLOYER has the right to and may impose pre-tax enrollment guidelines for all taxable benefit(s) available to its employees.