ORGANIZATION NAME

Premium Only Plan - Election Form

Name: _____

Social Security Number: _____

1. **Enrollment Type** (Check One): Effective Date is January 1, 202**X** or the first of the month following your date of hire or the date the enrollment form is signed*, if later. You cannot be reimbursed for expenses incurred prior to the Effective Date.

- o Annual Open Enrollment for plan January 1, 202**X** through December 31, 202**X**
- o New Hire Enrollment for _____ (effective date*) through December 31, 202**X**
- o Revised Enrollment due to Employment Status Change for _____ (effective date*) through December 31, 202**X**
- o Revised Enrollment due to Family Status Change for _____ (effective date*) through December 31, 202**X**

2. **Election and Contribution**: I am enrolling in (check as many as apply):

- o Premium Only Plan: Money set aside in this account will be used to pay the cost of your health insurance premiums. I elect salary reduction in the amount necessary to satisfy the required contribution I am expected to pay toward the cost of coverage for which I am eligible under the organization's group insurance plan. I understand that this is a pre-tax option and my Social Security Benefits may be reduced as a consequence of this election.
- o I do not wish to elect salary reduction, please take the necessary contribution as a post tax salary deduction.
- o I do not wish to elect the coverage for which I am eligible and certify that I and/or my dependents are covered under another insurance plan.

3. **Authorization and Agreement**:

The required contribution amount will be taken in equal installments on an annual basis from my paychecks while I am enrolled in this plan.

I understand that this authorization is irrevocable until the next election period unless I have a change in family status and the change I wish to make to my election is consistent with that change in status as specified in the Internal Revenue Code and regulations. All changes must be reported and a new election form must be completed within 30 days of the change.

Signature:_____Date_____