S125 FLEXIBLE BENEFIT PLAN PREMIUM WAIVER FORM

Enrollment Date: ____________ **Employer:** ____________ **Plan Year:** ____________

Employee Name: ______________________________ **Date of Birth:** ____________

Date of Hire: ____________ **Social Security Number:** ____________

Address: ______________________________ ☐ Check if address is new/changed

City: ____________ **State:** _____ **Zip Code:** ____________ **Pay Frequency:**

I UNDERSTAND THAT:

1. There are many advantages and disadvantages of participating in the Premium portion of this S125 Plan and I have decided NOT to participate at this time
2. I will not have another opportunity to enroll until the beginning of the next Plan Year or if I experience a change in family status as defined by the S125 Internal Revenue Code.

I hereby authorize my employer to deduct from my salary, or other compensation, the required contributions for my group health insurance plan after appropriate tax deductions have been made.

____________	____________	____________
Date	Employee Signature	Witness Signature