

**PREMIUM CONVERSION WAIVER FORM**  
**(Rescind Section 125 for premium payment)**

EFFECTIVE DATE \_\_\_/\_\_\_/\_\_\_

**1. Employee Data (Please Print)**

ID # \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_  
          **Last**                  **First**                  **MI**

Address \_\_\_\_\_  
          **Street**  **City**  **State**  **Zip**

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**By completing this form, your premium payments will be paid on a *taxed* basis year after year. If you want your premiums to be paid on a *pre-tax* basis under Section 125, you should not complete this form.**

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**2. Place an (x) on the line next to the coverage(s) you carry through your Employer.**

**Medical Plan:**    \_\_\_ Children    \_\_\_ Spouse    \_\_\_ Family

**Dental Plan:**    \_\_\_ Employee    \_\_\_ Employee & Children    \_\_\_ Employee & Spouse    \_\_\_ Employee & Family

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**3. List name, social security number, relationship and birth date of your spouse and all dependents.**

<b>Name</b>	<b>Soc. Sec. #</b>	<b>Relationship</b>	<b>Date of Birth</b>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

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By signing this document, I elect to waive all pre-tax premium conversion under the Plan. I understand that if I have enrolled for group medical and/or group dental insurance coverage on a separate benefit enrollment form, that I will pay my share of the contribution with after-tax payroll deductions. Except for a Change in Status Event for the applicable Benefit (as described in the plan document), I understand that I cannot elect pre-tax benefits until the next Open Enrollment Period, and any after-tax coverages shall be outside the Plan.

**4. Signature**

I have read and I understand the Premium Conversion Waiver information as outlined.

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*