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

EFFECTIVE DATE ___/___/___

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1. Employee Data (Please Print) ID #___________________________

Name____ Soc. Sec. Number___________________________
Last **First** **MI**

Address____
Street **City** **State** **Zip**

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: ___Employee ___Children ___Spouse ___Family

Dental Plan: ___Employee ___Children ___Spouse ___Family

Vision Plan: ___Employee ___Children ___Spouse ___Family

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.

3. Signature

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

____ ___________________________
Employee's Signature ***Date***