

# BENEFITS DESIGN GROUP, INC.

PO BOX 370 Onalaska WI 54650 1-800-554-7213 or (608) 781-2159

## PREMIUM ONLY ENROLLMENT FORM

Employer				Effective Date Month Day Year / /	
Employee Name: First Middle Initial Last			Social Security #		Birth Date Month Day Year / /
Union Member Y N	1st Deduction Month Day Year / /	Deduction Frequency 12 24 26 52 Other (please indicate) _____		Hire Date Month Day Year / /	Participation Status New Enrollment Re-Enrollment

Group Premium Accounts <i>(select all that apply)</i>	Per Pay Period Election	Plan Year Annual Election	For Office Use Only
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I request the following amounts to be deducted per pay period on a Pre-Tax basis:

MEDICAL PREMIUM	\$ _____	\$ _____	\$ _____
DENTAL PREMIUM	\$ _____	\$ _____	\$ _____
TERM LIFE PREMIUM <i>(Up to \$50,000 max death benefit)</i>	\$ _____	\$ _____	\$ _____
DISABILITY PREMIUM	\$ _____	\$ _____	\$ _____
OTHER _____	\$ _____	\$ _____	\$ _____
<b>TOTAL PRE-TAX DEDUCTIONS</b>	\$ _____	\$ _____	\$ _____

I request the following amounts to be deducted per pay period on an After-Tax basis:

AFTER-TAX DEDUCTIONS	\$ _____	\$ _____	\$ _____
<b>TOTAL DEDUCTIONS</b>	\$ _____	\$ _____	\$ _____

**AUTHORIZATION:** I certify the above information to be correct and true to the best of my knowledge. I understand that the above election(s) will be in effect for the plan year and cannot be revoked unless a qualified change of status is experienced by me, my spouse, or one of my eligible dependents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**DECLINATION OF PARTICIPATION:** I have been given the opportunity to participate in the above plan and have elected not to do so.

Signature \_\_\_\_\_ Date \_\_\_\_\_