PREMIUM ONLY PLAN WAIVER FORM

Return completed form to your employer

Employer Information

Employer Number: ______________________________

Employer Name: ______________________________

Plan Year: ____________________ through: ____________________

Employee Information

Employee Social Security Number: ______________________________

Employee Name: ______________________________

Waiver Signature

I elect NOT to participate in my employer's Premium Only Plan. The Premium Only Plan is one component of a cafeteria plan that allows employees to use pretax dollars to pay for their portion of the cost of employer sponsored group insurance premiums, such as accidental and health plan coverage (major medical coverage), dental, vision, and/or disability (STD/LTD). I understand that my portion of group insurance coverage premiums will be paid with after-tax dollars.

______________________________ ______________________________

Employee Signature Date

NOTE: IF YOU DO NOT RETURN THIS FORM TO YOUR EMPLOYER PRIOR TO THE EFFECTIVE DATE OF THE PLAN, YOU WILL BE AUTOMATICALLY ENROLLED IN YOUR EMPLOYER'S PREMIUM ONLY PLAN.

Questions? Call Member Services at 1-800-859-2144.