

ELECTION OF BENEFITS AND SALARY REDUCTION AGREEMENT

IMPORTANT NOTE: YOU MUST ALSO COMPLETE A PRODUCT APPLICATION FOR ANY COVERAGE ADDED. ANY EXISTING COVERAGE NOT LISTED WILL BE DROPPED FROM PAYROLL DEDUCTION.

Employee Name: _____ SSN: _____ Date of Birth: _____
 Employer: _____ Occupation: _____ Location: _____
 Annual Pay Periods: _____ Remaining Pay Periods: _____ Eff. Date: _____ Plan Year: _____ Emp ID: _____

PRE-TAX ELECTIONS – Voluntary 403(b) and 457 Plan elections

Plan Type: (Check one) 403 (b) 457 (PST Requires Additional Election Form)

Name of Company	Product	Current Pay Period Amt	New Annual Deduction	New Pay Period Amt
<i>Investment</i>				
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
TOTAL Pre-Tax Investments Election		_____	_____	_____

Flexible Compensation (“Cafeteria”) Plan Election

<i>Investment Premiums</i>				
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
<i>Medical Expense Reimbursement Plan</i>				
<i>Medical Premiums Reimbursement Plan</i>				
<i>Dependent Care Deduction Plan</i>				
TOTAL Cafeteria Plan Election		_____	_____	_____

AFTER-TAX ELECTIONS

1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
TOTAL After-Tax Deductions		_____	_____	_____

____ Waiver of Participation: I have reviewed the merits of this plan and hereby waive my rights of participation until the next plan anniversary date.

I hereby elect to participate in the above plans. I authorize the above payroll reductions/deductions as my contributions to the VOLUNTARY 403(B), 457, CAFETERIA PLANS AND/OR SUPPLEMENTAL PRODUCTS and agree that these will be automatically renewed each successive Plan year unless changed by me in writing. I Understand that changes in Cafeteria Plan elections can only be made at the end of the plan year unless due to a change in family status. Any amount in my Cafeteria Plan account not claimed by me by the end of the plan year will be forfeited. My employer may reduce or cancel any of my elections if necessary to comply with the Internal Revenue Code. I have read, understand and agree with the Summary Plan Description and the Sales Brochure(s) provided by each company above. This authorization replaces any previous authorization I have made.

Signature of Participant

Date Signed

Signature of Sales Representative

Date Signed