

Flexible Benefits Plan

Elective Contributions Form

Employer Name (Print and please press hard.) _____ Department _____

Employee Name (Last, First, Middle) _____ Social Security No. _____

Employee Street Address _____ City _____ State _____ Zip Code _____

Please complete all the above information for all plan participants.

No. of Pay Periods Per Year _____	Hours regularly worked each week for this employer _____
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I understand that I have an amount of flexible pay equal to \$_____ per pay period for the purchase of qualified benefits. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown below. Such reductions, considered as elective contributions under the plan, shall commence with my paycheck dated _____. I further authorize future adjustment in the amount of the salary reduction in the event that the cost of coverage in any program selected below under the heading "Premium Only Plan" is changed during the plan year.

I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per-deduction-period cost and the amount to be paid by salary reduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit* (All amounts should be per deduction period.)	Salary Reduction Amount Per Pay Period	No. of Reductions Per Year	Annual Election Amount
Premium Only Plan			
Group Medical	_____	_____	_____
Group Dental	_____	_____	_____
Group Term Life	_____	_____	_____
Group Disability	_____	_____	_____
Colonial Products (list products elected) ...	_____	_____	_____
_____	_____	_____	_____
Cancer (other than Colonial)	_____	_____	_____
Accidental Death and Dismemberment	_____	_____	_____
Vision	_____	_____	_____
Other	_____	_____	_____
Other	_____	_____	_____
Dependent Care Reimbursement Plan			
Coverage Effective Date _____	_____	_____	_____
Health Care Reimbursement Plan			
Coverage Effective Date _____	_____	_____	_____
Totals	_____	_____	_____
After-Tax Administrative Fee _____	_____	_____	_____

*I understand that only benefits listed in my employer's Flexible Benefits Plan document are available. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of a child, and termination of employment of spouse.)

I understand that the insurance claim payments under certain coverages may be subject to federal and state taxes when the premium is paid by salary reductions or employer contributions.

AUTHORIZATION I certify the above information to be correct and true and any dependents for which I have selected the dependent care benefit reside with me in a parent-child relationship and/or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I hereby authorize the deduction of the administrative fee, if applicable.

Signature _____ Date _____

IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline to participate.

Signature _____ Date _____

White - Benefited America Yellow - Representative Pink - Employer Gold - Employee 40925-4