

ADVANTAGE[®] PAYROLL SERVICES

Precision You Can Count On

EMPLOYEE PREMIUM ONLY CAFETERIA PLAN ENROLLMENT FORM

Client # _____

New Hire
 Newly Eligible

Reason _____
Effective Date _____

Employer: _____

Employee #: _____ Social Security #: _____

Employee's name (Last, First, Middle): _____ Date Employed: ____/____/____

Are you an owner, shareholder, family member of a shareholder or officer of this business? If yes, check below and read next paragraph.

OWNER
 OFFICER
 SHAREHOLDER (indicate % of ownership) _____ %
 FAMILY MEMBER OF SHAREHOLDER (indicate the shareholder's name) _____

Sole proprietors and partners are prohibited by IRS from participating in premium conversion cafeteria plans. 2% shareholders of S-Corps, their spouses, and family members also cannot participate. Plans are discriminatory when the deductions of highly compensated and key employees are greater than 25% of the total deductions of ALL participants or when participation or eligibility favors highly compensated employees. If a plan is found to be discriminatory, wage corrections will be necessary to reduce or eliminate deductions of highly compensated or key employees.

Hours regularly worked each week for this employer: _____ hrs/wk Pay Period: W BW SM M

Group Health Premium \$ _____
Group Dental Premium \$ _____
Group Disability Premium \$ _____
Other Premium \$ _____

TOTAL PREMIUM TO BE PAID WITH PRETAX DOLLARS \$ _____

AUTHORIZATION:

I certify that the above information is correct and true to the best of my knowledge. I further understand that my salary deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a qualified change in my family status. Deductions will continue into subsequent plan years if I do not submit a new enrollment form at renewal time.

Employee Signature: _____ Date: _____

IF YOU DECLINE PARTICIPATION:

The benefits of the plan have been thoroughly explained to me and I decline to participate at this time.

Employee Signature: _____ Date: _____