

Individual Premium Account Enrollment Form

Instructions: Complete each section, sign, date the form and return to your Human Resources Dept.

Section I – Employee Information (Please print)

Social Security #	Employer – New Dawn, Inc.		
Participant Name (Last, First, MI)	Date of Birth		
Email Address			
Home Address	City	State	Zip

Section II – Individual Health Insurance Plan Information (Please print)

Insurance Carrier Name	Effective Date of Insurance Coverage
------------------------	--------------------------------------

Section III - Account Elections (Please print)

Individual Premium Account: I elect \$ _____ per payroll or \$ _____ for the plan year to be contributed on a pre-tax basis to my Individual Health Care Premium Account.

I hereby authorize my employer to deduct from my pay on a pre-tax basis the amounts elected above for the Plan Year. I understand that the payroll deducted amount will be available for the reimbursement of my individual health insurance premiums in accordance with the terms of the formal Plan Documents and while I am a participating employee.

Employee Signature _____ Date _____

Section IV – Mid-Year Account Elections (Check the proper box, indicate the date of the change, sign & date the section)

Complete this section only if you are eligible to enroll mid-year or change your previous election due to a family status change. Mid-year enrollments and election changes MUST be requested within 30 days of the change.

- | | |
|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Termination of Employment |
| <input type="checkbox"/> Death of Spouse or Child | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Birth or Adoption of Child | <input type="checkbox"/> Commencement or Termination of Employment of Spouse |
| <input type="checkbox"/> Change from Full-Time to Part-Time or Part-Time to Full-Time status by employee or employee's spouse | |
| <input type="checkbox"/> Significant Change in Health Coverage due to Spouse's Employment | |

I hereby revoke my previous deduction authorization for the current Plan Year and authorize my employer to make the payroll deductions indicated above for the remainder of the Plan Year.

Employee Signature _____ Date _____

Section V for Employer Use Only (Complete This Section For Any mid-year enrollments or changes)

Plan Sponsor / Employer Name _____ Location _____

Effective Date _____ 1st Payroll Change _____

Signature of Plan Administrator _____

BENEFIT EXTRAS, INC. (Fax #952-435-8435; toll-free #800-886-8793)