Select Data Service Administrators, Inc.
P.O. Box 2076
Batesville, AR 72503
Toll-free Fax: 1.888.877.4747

PREMIUM PAYMENT PLAN ENROLLMENT FORM

(Please complete and sign form. Please PRINT clearly.)
- Confidential -

Employer Name: _____ Worksite: _____

Employee Name: _____ Social Security No: _____ - ____ - _____

Number of Deductions: _____ Date of First Deduction: _____ Effective Date: _____

Premium Rate Per Pay Period:

Medical	$_____	Life	$_____	Accident	$_____
Dental	$_____	ICU/CCU	$_____	Other	$_____
Cancer	$_____	Heart/Stroke	$_____	Other	$_____

I hereby authorize and direct my employer to reduce my salary in the amount listed above under the Section 125 Program.

As a participant in the Premium Plan, I am entitled to revoke my elected benefit election in the event of certain changes in family status that are permitted as described and stated in the Plan Summary Plan Description.

Unless I notify my Employer, this election will automatically continue for each subsequent Plan Year.

My Social Security benefits may be slightly reduced as a result of my election.

I understand that the change in my benefit must be necessitated by and consistent with the change in family status and the change must be acceptable as described and stated in the Plan Summary Plan Description.

(Initials) I Decline To Participate In The Premium Payment Plan

_____ _____
Signature Date