



Employee Selection Form *Effective*

9/1/09 - 8/31/10

Please Print Clearly Below:

Administrative Use Only

Name: _____
 Address: _____

 Phone: _____
 Hire Date: _____
 Birth Date: _____
 Soc. #: _____

Effective Date: _____
 Open Enrollment: _____
 New hire: _____
 Change in Status: _____
 Address Change: _____
 No Changes: _____
 Changes: _____
 HBS enroll specialist: _____

MEDICAL / Rx BENEFITS (Priority Health)

*Please check the appropriate box.		Monthly Premium	Monthly Employer Contribution	Monthly Employee Contribution	Per-pay (24) Employee Contribution		
New Hire Benefits are effective the 1st of the month after 30 calendar days.							
A. Priority 100/70 PPO Buy Up Plan	Single	\$368.31	\$250.00	\$118.31	\$59.16	<input type="checkbox"/>	\$ Deduction Amount
	Employee + 1	\$810.28	\$250.00	\$560.28	\$280.14	<input type="checkbox"/>	
	Family	\$1,012.85	\$250.00	\$762.85	\$381.43	<input type="checkbox"/>	
	Family Continuation	\$0.00	\$0.00	\$0.00	\$0.00	<input type="checkbox"/>	
B. No Coverage		\$0.00	\$0.00	\$0.00	\$0.00	<input type="checkbox"/>	
C. Medicare Eligible	Self _____ Spouse _____						

DENTAL BENEFIT (Sun Life)

*Please check the appropriate box.		Monthly Premium	Monthly Employer Contribution	Monthly Employee Contribution	Per-pay (24) Employee Contribution		
A. PPO Dental Dentemax Network	Single	\$33.46	\$10.00	\$23.46	\$11.73	<input type="checkbox"/>	\$ Deduction Amount
	Employee + Spouse	\$71.38	\$25.00	\$46.38	\$23.19	<input type="checkbox"/>	
	Employee+Chid(ren)	\$75.71	\$25.00	\$50.71	\$25.36	<input type="checkbox"/>	
	Family	\$124.22	\$50.00	\$74.22	\$37.11	<input type="checkbox"/>	
B. No Coverage		\$0.00	\$0.00	\$0.00	\$0.00	<input type="checkbox"/>	

VISION BENEFIT (VSP)

*Please check the appropriate box.		Monthly Premium	Monthly Employer Contribution	Monthly Employee Contribution	Per-pay (24) Employee Contribution		
A. VSP 12/12/24	Single	\$9.72	\$0.00	\$9.72	\$4.86	<input type="checkbox"/>	\$ Deduction Amount
	Two Person	\$14.84	\$0.00	\$14.84	\$7.42	<input type="checkbox"/>	
	Family	\$26.61	\$0.00	\$26.61	\$13.31	<input type="checkbox"/>	
B. No Coverage		\$0.00	\$0.00	\$0.00	\$0.00	<input type="checkbox"/>	



*Employee Selection Form Effective
9/1/09 - 8/31/10*

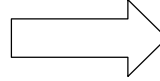
GROUP LIFE BENEFIT (Sun Life)

\$25,000 of group life benefit is provided to all eligible employees

No Deduction

ADDING IT ALL UP

Total amount to be deducted from each paycheck (24) on a Pre-Tax basis



\$

Total Deduction Amount

I have received and read all of the materials explaining this plan. I understand that I am making an election concerning my benefits for the full plan year and authorize any required salary reduction in accordance with my elections above. My elections are binding subject to any changes required to comply with federal law, such as a change in my family status. A change in family status may include, but is not limited to, marriage; divorce; death of a spouse or dependent; birth or adoption of a child; or a change in my (or my spouse's) employment status. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I hereby apply for the options listed above.

This enrollment form is not an agreement of employment

Signature _____

Date _____

EN-HANTZ YOUR BENEFITS™