

HEALTH PLAN ALTERNATIVES, INC
CAFETERIA PLAN ELECTION FORM

PLAN YEAR: ___/___ /___ THRU ___/___ /___
 mo day yr mo day yr

Company Name: _____

Branch/Dept: _____

Employee Name: _____

Employee Address: _____
 street city state zip

Employee Social Security Number: _____

I elect the following benefits offered by my employer under the Cafeteria Plan and agree that the amounts shown below will be reduced from my wages each pay period.

It is understood that my reductions will automatically be adjusted by my employer due to any increase or decrease in benefits.

It is understood that I will be given the opportunity by my employer to change my Cafeteria Plan benefit election prior to the beginning of each plan year. If I do not complete a new election form at that time, my current benefits listed below will continue for the new plan year.

	Per Pay Period
_____ Health Insurance	_____
_____ Dental Insurance	_____
_____ Life Insurance	_____
_____ Vision Insurance	_____
_____ Short Term Disability	_____
_____ Other	_____
_____ Other	_____

EMPLOYEE'S SIGNATURE: _____ DATE: _____

COMPANY REPRESENTATIVE: _____ DATE: _____
(WITNESS)

DATE ON WHICH FIRST REDUCTION WILL TAKE PLACE: _____