SimpleHR 2017 Benefits – Employee Election Form

Client Name	Employee Name		
Date of Birth	SSN#		
Address	City	State	Zip Code

Only Full Time employees (25+ hours per week) are eligible for benefits.

Please note that additional applications will be required for all elected benefits.

Please return all completed forms and applications to SimpleHR:

Phone: 850.650.9935 ext. 37

Fax: 850.650.9936

Email: acurtin@simplehr.com

ENROLLMENT OPTIONS OR CHANGES

GUARDIAN DENTAL, VISION (VSP), AND LIFE INSURANCE

	Dental	Vision	Life
Add Coverage	☐	☐	☐
Change Coverage	☐	☐	☐
Waive Coverage	☐	☐	☐

ALLSTATE SUPPLEMENTAL HEALTH PRODUCTS

	Accident	Critical Illness	Group Supplemental	Individual Products
Add Coverage	☐	☐	☐	☐
Change Coverage	☐	☐	☐	☐
Waive Coverage	☐	☐	☐	☐

ELECTION / DECLINATION ACKNOWLEDGEMENT

I understand that this election form revokes any prior election forms completed and will remain in effect and cannot be revoked or changed during the Plan Year, unless there is a change in family status, employment, or other reasons as outlined by the IRS rules for the Section 125 Plan. I understand I must complete an Enrollment Application for each benefit in which I elect coverage. I understand and agree that I am fully responsible at all times for any benefit premiums for which I have authorized and such premiums will be deducted from my wages when due.

Signature _____ Date _____