

# NORTHEAST KANSAS EDUCATION SERVICE CENTER

SECTION 125 BENEFIT SELECTION FORM  
PLAN YEAR SEPTEMBER 1, 2008 – AUGUST 31, 2009

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ Gender: Male  Female  Date of Hire: \_\_\_\_\_  
 City/St/Zip \_\_\_\_\_ Phone: \_\_\_\_\_ Salary \$ \_\_\_\_\_  
 Email \_\_\_\_\_ Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

## 125 BENEFITS MONTHLY PREMIUMS

<u>BENEFIT ELECTIONS</u>	<u>EMPLOYER PD</u>		<u>EMPLOYEE PD BEFORE TAX</u>		<u>EMPLOYEE PD AFTER TAX</u>		<u>COMPANY</u>
	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09	
Health E / ES / EC / F							BC/BS
Dental E / ES / EC / F							Delta or CompBenefits
Vision E / ES / EC / F							CompBenefits
Disability/Salary Protection Waiting Period 14 / 30 / 60 / 90 days							Reliance Std or Am Fid
Cancer/Dreaded Disease (additional Application required)							AIG or Am Fid
Heart & Stroke (additional Application required)							AIG
Voluntary GT Life – Amt \$ _____ (additional App. may be needed)							Reliance Std
Spousal Term Life – Amt \$ _____							Reliance Std
Dependent Term Life (\$10,000 ea.)							Reliance Std
Medical Flex							Security Benefit
Dependent Care Flex							Security Benefit

### DEPENDENT INFORMATION (SP/Children) (for Dental, Vision, GTL and Flex Accts.)

NAME	RELATIONSHIP	GENDER	SOCIAL SECURITY #	DATE OF BIRTH

For new applications or coverage changes, an application for insurance or the appropriate change form must be completed and accepted by the insurance company before the insurance is effective. **Coverage Changes:** No changes in coverage will be allowed in the plan year unless a family status change has occurred. The election change must be made within 30 days of the date the change occurred. This is an underwriting guideline which applies regardless of whether premiums are paid on a salary reduction or deduction basis.

A proposed insured must be actively at work full-time on the date the insurance would normally become effective. If not, the insurance will not become effective until the proposed insured has been actively at work for two consecutive days.

I hereby acknowledge that I have received a summary of the material terms of the plan and authorize deduction from my salary for the above salary deduction/reduction amounts.

I hereby authorize my employer to reduce my salary by the above salary reduction amounts to purchase employee fringe benefits under IRC Sec. 125. I understand that I may not change this reduction amount during the plan year except for circumstances defined in Sec. 125 regulations.

I elect NOT to participate in ANY benefits offered under the IRC Section 125 Cafeteria Plan.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

Retirement Plan Type _____	Company _____	\$ _____ Monthly
Retirement Plan Type _____	Company _____	\$ _____ Monthly