

HR Concepts, LLC

"Your Third Party Administrator of Choice"

Premium Offset Plan Enrollment Form

Company Name: _____

First Name: _____ Last Name: _____ SS#: ____ -- ____ -- _____

Street Address: _____ City: _____ St: ____ Zip: _____

Phone Number: _____ Spouse First Name: _____ Last Name: _____

I authorize my employer to make the following pre-tax reduction from my paycheck according to the election I have chosen below. This election cannot be changed until the beginning of the next plan year or if I have a qualifying event; which includes within my immediate dependents, marriage, divorce, death or birth. If I fail to make an election change upon the open enrollment for each plan year then my current election will automatically rollover as if I had elected to continue my election.

(PLEASE CHECK THE BOX OF THE BENEFITS YOU WANT TO PAY PRE-TAX)

- Health Insurance
- Dental Insurance
- Vision Insurance
- Life Insurance
- Disability Insurance

I understand that I cannot change my election during the plan year unless I have a qualifying event. My social security benefit may be reduced by this election. My election will automatically rollover each plan year if I fail to make a new election.

Employee Signature: _____ Date: _____

Accepted By Employer: _____ Date: _____



Flex Plans • HSA's • Commuter Plans • HRA's • Dental Plans • COBRA

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