P.O. Box 2076, Batesville, Arkansas 72503
Phone: (888) 698-1429 FAX: (888) 877-4747

Premium Only Plan Enrollment Form

INSTRUCTIONS: Please PRINT clearly and SUBMIT this form to Your Benefits Administrator.

View your account on-line at **www.selectdataservice.com**

SECTION I – PERSONAL INFORMATION

2. Employer Name		3. Full-Time Hire Date (Month / Day / Year)
4. Employee Name (Last Name, First Name, Middle Initial)		
5. Social Security Number	6. Birth Date (Month/ Day/Year)	7. Marital Status (choose one) ❑ Married ❑ Single ❑ Divorced
8. Employee Mailing Address (Street, City, State, Zip)		
9. E-Mail Address	10. Home Phone ( )	11. Work Phone ( )

SECTION II – BENEFIT PREMIUMS

Select Benefit(s)	Benefit	Annual Amount	Monthly Premium	Per Pay Period	Taxable
❑	Health Insurance				
❑	Dental Insurance				
❑	Group Term Life				
❑	Cancer Insurance				
❑	Heart/Stroke				
❑	Accident				
❑	AD&D				
❑	Hosp. Indem.				
❑	Other ____________________				
	Total Premiums:				

SECTION III – AUTHORIZATION / EMPLOYEE SIGNATURE

I understand that:

- This election will remain in effect for the duration of the plan year.
- The Administrator is authorized to adjust the amount of my salary redirection's and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
- My employer cannot be responsible for any tax liabilities, which I may incur as a result of my participation in the Plan.
- I cannot suspend, increase or decrease these deductions during the plan year unless I experience a valid change in status.

I authorize payroll deductions for the total amount(s) indicated into my selected Plan Accounts, and certify that I have read both sides of this enrollment form.

17. Employee Signature	18. Date
______________________________	______________________________