



2007 BENEFITS ENROLLMENT FORM

Name: _____

Social Security Number: ____/____/____

MEDICAL OPTION:

MONTHLY DEDUCTION:

Table with 3 columns: Individual Monthly Deduction, Individual + 1 Monthly Deduction, Family Monthly Deduction. Rows include Meritain PPO, Meritain CHA HMO, Meritain Select HMO, No Coverage - Non ND Spouse, No Coverage - ND Spouse.

Medical Deduction box

DENTAL OPTION:

Table with 3 columns: Individual Monthly Deduction, Individual + 1 Monthly Deduction, Family Monthly Deduction. Rows include Delta Premier PPO, Delta Preferred POS.

Dental Deduction box

VISION OPTION:

Table with 3 columns: Individual Monthly Deduction, Individual + 1 Monthly Deduction, Family Monthly Deduction. Row includes EyeMed.

Vision Deduction box

LIFE INSURANCE OPTION: (choose option 1-10 times your annual salary)

Table with 3 columns: Option (1-10), Coverage Amount, Monthly Deduction. Rows include Basic Only (\$25,000), Optional Life (1-10X).

Life Insurance Deduction box

DEPENDENT LIFE INSURANCE:

Table with 2 columns: Monthly Deduction. Rows include \$12,500 for Spouse, \$ 5,000 each Child, Not Participating.

Dependent Life Deduction box

FLEXIBLE SPENDING ACCOUNTS:

Health Care Account. Enter your annual and monthly Health Care Account Contribution. (Minimum \$120/year and Maximum \$5,000/year)

Annual Contribution and HCAR Deduction boxes

Dependent Care Account. Enter your annual and monthly Dependent Care Account Contribution. (Minimum \$120/year and Maximum \$5,000/year per family)

Annual Contribution and DCAR Deductions boxes

TOTAL MONTHLY DEDUCTIONS

Arrow pointing to a shaded box for total monthly deductions

I have read the printed materials about my benefit plans. I understand that by signing this form, I authorize the elections that I have made and any deductions from my pay. I certify that if I have elected no medical coverage, I have coverage elsewhere and have completed the Verification of Other Medical Coverage Form. If I am married or have dependents and have elected Individual Medical Coverage, I have completed the Verification of Other Medical Coverage Form. And I understand that these elections will remain in effect until the next plan year unless a change in family status occurs.

Signature: _____

Date: _____