



Section								
	П	П		П		П		
				_		_		
					Effective D	ate of Change:	/ /	
Section 2 - Er	mployee Inform	ation ( <i>Please Prir</i>	nt .					
		Phone Numb	oer:	Email address:				
Mailing Addre	ess:							
Physical Addr	ess		:					
For the Bene	efits Departmer	nt use only:						
Annual Salary		Hire Date:	Occupation:		Location:			
Hours worked	d:	Pay Frequency:122026	Effective Date	<del>)</del> :	Terminatio	Termination Date:		
Section 3 - Fa	amily Informatio	on ( <i>Please Print)</i>						
Dependent Na	ame			SSN	DOB	M/F	Add or Drop	
Spouse								
Child								
Child								
Child								
Child								

Section 4 - B	<u>enefit Selecti</u>	<u>on (</u> Please indic	ate election by usi	ng an "X")		
TRS Medical	Pre-Tax		Decline	Flexible Spending Accounts	Pre-Tax	Decline
					3	3,050
				Health Savings Account Pre-	Tax (Can only chang	e amount)

Accident

## Section 5 - Beneficiary Designation (Please Print) Contingent Beneficiary: Primary Beneficiary: Name\_ Name\_ Date of Birth\_\_\_\_\_ Date of Birth\_\_\_\_\_ Relationship\_\_\_\_\_ Relationship\_\_\_\_\_ Percentage\_\_\_\_\_ Percentage\_\_\_\_ Section 6 - Signatures This election form revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status. I understand that I have verified the benefits elected above and authorize any payroll deductions required for those elections. \_\_\_\_\_/\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_/\_\_\_\_ Employee Signature: x\_\_\_ Benefits Administrator Signature: x\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_