Premium Only Plan
Enrollment Form

Employer Name: KeyStaff, Inc.	Social Sec Number:
Employee Name:	Plan Year: 1/1 - 12/31
Address:	
City/State:	ZIP:

Pretax premium elections

☒Medical $____________

Authorization

I authorize the adjustment to my annual base salary based on my elections above. I understand that by signing and submitting this form I am making a binding election for the plan year as stated unless such revocation or new election is on account of and consistent with a change in status (e.g., marriage, divorce, death, and termination of employment of spouse). I further understand that this form must be signed and dated prior to my plan effective date in order to be eligible to participate in this plan year.

Signature_________________________________ Date ______/______/______

Declination

The benefits of the plan have been thoroughly explained to me and I decline to participate. I understand that I cannot re-enroll until the beginning of the next plan year or until I experience an election change event that would allow me to change my election.

Signature_________________________________ Date ______/______/______