HEALTH PRE-TAX ELECTION FORM

☐ **NEW** ☐ **CHANGE** Pay Periods Per Year: 26

Employee's Last Name, First Name, Middle Initial			
Address: P.O. Box, City, State, Zip Code			
Date of Birth	Social Security Number	Program	Work Telephone Number

ELECTION OF PRE-TAX HEALTH BENEFITS - Select the benefits you want to pay on a pre-tax basis
I elect to have the following premiums deducted from my pay on a pre-tax basis bi-weekly:

Covered Individual(s)	**PREMIUM PER PAY PERIOD** **Medical**	**Dental**	**Vision**	**Total**
☐ Spouse	$	$	$	$
☐ Child/Children	$	$	$	$
☐ Family	$	$	$	$

Pre-Tax Health Premium Payment Rules

I understand I cannot change or revoke my coverage or premiums at any time during the plan year unless I have a change in status including, but not limited to, marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment. Subject to strict IRS timing rules, the Plan Administrator will permit a change or revocation of an election in the event of a change in status.

I understand that I must continue coverage and the contributions from my pay check for my dependent's coverage, if any, until the next open enrollment period or until I have a special enrollment event.

I understand if the premiums for my elected benefits are insignificantly increased or decreased while this agreement is in effect, my payroll deductions will automatically be adjusted to reflect that increase or decrease. A significant increase or decrease qualifies as a change in status.

I understand I will be offered the opportunity to change my benefits election for the upcoming plan year during open enrollment. Open enrollment procedures vary from time to time and the plan administrator will notify me whether new elections are required for the upcoming plan year.

I understand any health premiums (medical, dental or vision) that I pay through payroll deductions, will be deducted from my pay on a pre-tax basis (before Income, Social Security and Medicare Taxes are deducted), thereby reducing my taxable income.

AGREEMENT AND AUTHORIZATION

This agreement is subject to the terms of the Tribe's Health Plan, as amended from time to time, and shall be governed by and construed in accordance with the Internal Revenue Code and Hopi Law.

This Agreement revokes any prior election and contribution agreement relating to such plan(s). The Office of Human Resources may reduce or cancel my contribution or otherwise modify this agreement if it deems it advisable in order to satisfy certain provisions of the Internal Revenue Code.

I authorize the Employer to deduct bi-weekly payments for the Dependent Health Insurance coverage(s) selected above.

I also authorize on behalf of myself and my enrolled dependent(s) the use of a Social Security Number for the purpose of identification. I understand and agree that any omission or incorrect statements made on this application may invalidate the health coverage for myself or my dependent(s).

I further understand that coverage will become effective only on the date specified by the Plan Administrator. By signing this form, I hereby certify that all information provided is true and correct.

Employee Signature: _____ Date: _____

EMPLOYER / ADMINISTRATOR USE ONLY	
Address Change	
Coverage Effective Date:	**Annual Salary:** **Salary Effective Date:**
COMMENTS	
DATE PROCESSED BY HR: *Employer/HR Signature:*	