



HEALTH & RETIREMENT 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
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I. ELECTION OF PRE-TAX HEALTH BENEFITS – Please 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)	<u>PREMIUM PER PAY PERIOD</u>			
	Medical	Dental	Vision	Total
<input type="checkbox"/> Spouse	\$	\$	\$	\$
<input type="checkbox"/> Child/Children	\$	\$	\$	\$
<input type="checkbox"/> Family	\$	\$	\$	\$

Pre-Tax Health Premium Payment Rules

I understand that:

- 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.
- 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 will be offered the opportunity to make or modify my benefits election for the upcoming plan year during open enrollment. If I do not complete and return an election form at that time, I will be treated as having elected not to participate for the upcoming plan year.
- 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.

II. ELECTION OF 401(k) RETIREMENT CONTRIBUTIONS

I understand that if I have previously elected to contribute to the Hopi Tribe 401(k) Retirement Plan (the "Retirement Plan"), that election will continue unless I modify that election below or cease contributing to the Plan by completing Section IV.

I ELECT to contribute the following portion of my Earnings to the Plan*:

Employee Pre-Tax Contributions (1% to 70%)	%
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*I understand, however, that I may change my election with regard to the Retirement Plan at any time during the year.

III. AGREEMENT AND AUTHORIZATION

This agreement is subject to the terms of the Tribe's Health, Premium Conversion and 401(k) Retirement Plans, 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) and/or Retirement Plan contributions 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: _____

IV. WAIVER OF 401(k) CONTRIBUTIONS

I WAIVE voluntary contributions into the 401(k) Retirement Plan:

Employee Signature: _____

Date: _____

EMPLOYER / ADMINISTRATOR USE ONLY		
Employee 401(k) Pre-Tax Contributions:	Percentage _____%	Effective Date:
Address Change		
Coverage Effective Date:	Annual Salary:	Salary Effective Date:
COMMENTS		
DATE PROCESSED BY HR:		Employer/HR Signature: