

## **Salary Redirection Agreement**

Name:			
Address:		City/State:	Zip:
equal to the total amount of premit contribution allocable thereto will amended or terminated. The amou In the event of a rate change, I authnew Salary Redirection Agreement coverage I select. Any previous elebelow are hereby revoked. My emacceptance of this Agreement.	m and/or be withhe nt of my norize a co . I under ection and ployer's o	contribution for coverage(s) elected lead from my salary, continuing for each required contribution is set forth on a corresponding change in the amount de	h pay period until this agreement is schedule that has been provided to me. ducted from my salary without signing ay be higher or lower depending on the ng to the same benefits as selected
Check the desired coverage(s) b	elow:		
<u>P1</u>	e-tax	After-tax	
Medical Coverage — Dental Coverage — Vision Coverage —			
I understand and agree that:			
year, unless I have a Chang adoption of a child, or term 2. Signing this form does not	ge in Statu ination o initiate m		•
I agree to the terms of participation compensation by the amount of my		orm and in related Plan Documents. I Elections of the eligible plans.	authorize my employer to adjust my
Employee Signature			Date
Employee Printed Name			