CPA, INC.
420 Washington Street, Suite LL8
Braintree, MA 02184
(800) 544-2340 (Toll Free)
(781) 848-9848 (Direct)
(781) 848-8477 (Fax)

PREMIUM ONLY PLAN

AUTHORIZATION FOR CAFETERIA PLAN PAYROLL REDUCTION

EMPLOYER: _____ PLAN YEAR: _____

EMPLOYEE: _____ SS#: _____ - _____ - _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ EMAIL ADDRESS: _____

PHONE: (_____)_____ ANNUAL SALARY: $ _____

D.O.B. _____ / _____ / _____ D.O. HIRE: _____ / _____ / _____

PAY CYCLE: (Circle One) Weekly (52) Bi-Weekly (26) Semi-Monthly (24) Monthly (12) Other: _____

PRE-TAX PREMIUMS:

Medical _____ Dental _____ Other _____

I hearby authorize a salary reduction for the amounts shown above. I understand that this election CANNOT BE REVOKED during the plan year unless there is a qualifying event.

PARTICIPANT S'SIGNATURE: _____DATE:_____

The Cafeteria Plan under Section 125 has been offered to me and I understand its benefits. I decline to participate at this time.

DECLINATION SIGNATURE: _____ DATE: _____