

**Finlandia University
Premium Election Form**

- Correction
- Change of personal information
- Change of Family Status
- Transfer
Effective Date: _____
- Termination
- Waive Participation _____ (initial)

Personal Information

Last Name	First Name	Middle Initial	Social Security Number	
Home Address	Street	City	State	Zip
Date of Birth: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Hire: / /	

Benefit Elections (Circle coverage elected and enter appropriate amount on total cost per month line.)
(Employee Cost Per Month*)

Name of Benefit Plans To Be Offered	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
* Amount after employer contribution is deducted				Total Cost Per Month \$ _____

Salary Reduction Agreement

I have read and understand the explanation I have received regarding my options under the Finlandia University Premium Only Plan. I understand I have the right to have the company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the medical coverage I have designated above. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; a change in worksite; or any change in employment status that affects eligibility; a change in residence for me, my spouse or children; or my dependent either satisfies or ceases to satisfy requirements for coverage due to change in age, student status, or any similar circumstances; or a change in my or my spouse's employment status.

It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy. I understand that subsidized insurance premiums can only be deducted on a post-tax basis.

I hereby apply for the options listed above. If necessary, I authorize Finlandia University to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from January 1 until December 31, unless my family status changes.

Employee Signature

Date

Company Representative

Date