Premium Deduction Authorization/Waiver of Participation

Company Name____

Employee's Name____

Home Address____

SSN________________________________

I hereby authorize my employer Applied Staffing Solutions PEO LLC to deduct from my earnings such amounts as may now or hereafter be payable by me under the insurance plan that I have selected.

☐ I wish to have my deductions taken out of my check on a **Post-Tax** basis.
☐ I wish to have my deductions taken out of my check on a **Pre-Tax** basis.

I understand that any **pre-tax** elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a qualifying event.

I certify the information above to be correct and true to the best of my knowledge. I authorize payroll deductions from my earnings for any contribution I am making toward the cost of any of the above. Applicable account(s) at the end of the plan year not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Section 125 Plan deductions(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status as defined in the Plan Document.

Signature of Applicant_________________________________ **Date**___________

Insurance Effective Date:_______________	
Medical - $500 Deductible	
Employee	$________
Employee + Spouse	$________
Employee + Child(ren)	$________
Employee + Family	$________
Medical - $1000 Deductible	
Employee	$________
Employee + Spouse	$________
Employee + Child(ren)	$________
Employee + Family	$________
Medical - $2500 Deductible	
Employee	$________
Employee + Spouse	$________
Employee + Child(ren)	$________
Employee + Family	$________
Best Dental	
Employee	$________
Employee + Spouse	$________
Employee + Child(ren)	$________
Employee + Family	$________
VSP Vision	
Employee	$________
Employee + 1	$________
Employee + Family	$________
FSA Deductions	
Day Care Expenses (Annual Total) **20**_____	$ per Yr_____
Medical Expenses (Annual Total) **20**_____	$ per Yr _____

Waiver of Participation

I certify that the features and benefits of Applied Staffing Solutions PEO LLC health coverage's have been explained to me completely.

I understand that these programs are offered through my employer by payroll deduction.

☐ I do NOT currently have health coverage with Applied Staffing Solutions PEO LLC and have decided to waive my opportunity to participate at this time.

☐ I do currently have health coverage through Applied Staffing Solutions PEO LLC and have decided to waive my opportunity to participate during the next plan year.

Employee Signature________________________________ **Date**_____________