



Special Notes:

PREMIUM ONLY PLAN (POP) ENROLLMENT FORM/CHANGE OF STATUS

COMPANY NAME: _____ COMPANY ID: CHO

Effective Date: _____ Date of First Payroll Reduction: _____

Please check one:

- This is a regular annual election
 I am a new employee
 There has been a change in my family status
 This is a termination

Marital Status:

- Single
 Married
 Legally Separated
 Widowed
 Divorced

Employment Date:

Birth Date:

Change is due to:

- Marriage
 Spouse became employed
 Change in work hours
 Divorce/separation
 Change of address
 Other (please explain): _____
- Death of spouse/child
 Spouse ceases to be employed
 Unpaid Leave of absence
 Birth or adoption of child
Date change occurred: _____

I participate in the health plan as a:

- Single
 Employee & Spouse
 Employee & Child
 Family
 I do not participate in the health plan

Social Security Number:

Last Name (please print)	First Name	MI	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Mailing Address (Street or PO BOX)	City	State	Zip	
Phone Number	Email Address - Necessary to receive email communication on your account			

PLAN YEAR ELECTION –

I authorize my employer to deduct a pre-tax contribution from my compensation for the following benefits:

- Premiums for my group plans offered by my employer (group medical plan, dental, etc.)
If you have elected to pay your group plan premiums through this plan, the full amount of your premiums due per pay cycle will be deducted from your compensation on a pre-tax basis. The amount will depend upon which group benefits you participate in.

AUTHORIZATION OR WAIVER OF PARTICIPATION

I request to participate in the benefits indicated above. I understand that my election indicated above are binding upon me for the entire Plan year. Under penalty of perjury, I understand that these expenses cannot be claimed on my income tax return. By signing this form I hereby authorize my employer to deduct any eligible premium from my paycheck.

- I elect to participate in *The Choice Care Card™* POP plan
 I do not elect to participate in *The Choice Care Card™* POP plan

By signing below I hereby authorize the release of claim information to my employer, their broker, and *The Choice Care Card™* administrator.

Employee Signature: _____ Date: _____