Paychex Use Only
Client BIS ID _______________

ENROLLMENT/WAIVER FORM
PAYCHEX PREMIUM ONLY PLAN

PAYCHEX PAYROLL CLIENT Notify your payroll specialist of employee deduction changes and maintain this form for your records. Office/Client Number ______________________________ **Do not** forward this form to the Section 125 Department.	**NON-PAYROLL CLIENT** Advise your payroll service or payroll department of employee deduction changes, and mail or fax a copy of this form to: Paychex Attn: Section 125 Department 1175 John Street, West Henrietta, NY 14586 Fax: 877-405-6219 Paychex Employee Services: 1-877-244-1771

EMPLOYER INFORMATION

Company Name ____ (PRINT) Telephone Number (_____) __________ - ______________

Address ____ City ____________________ State ____ Zip ___________

☐ CHECK HERE IF THIS IS A NEW ADDRESS

EMPLOYEE INFORMATION

Name ____ (PRINT)

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ **I elect to participate in the Premium Only Plan.** My premium payments will be paid on a pretax basis.
COMPLETE THE EMPLOYEE ENROLLMENT INFORMATION BELOW.

☐ **I elect *not* to participate in the Premium Only Plan.** My premium payments will be paid on an after-tax basis. I may not change my election until the next plan year.

EMPLOYEE ENROLLMENT INFORMATION (COMPLETE ALL INFORMATION)

Enrollment Date _______ / _______ / _______ Deduction Frequency __________ (NUMBER OF PAY PERIODS)

First Check Date _______ / _______ / _______

	Employee Per-pay-period	x	Number of Pay Periods	=	Annual Premium
Health Benefit	$ ____________	x	$ ____________	=	$ _____________
Dental Benefit	$ ____________	x	$ ____________	=	$ _____________
Life Benefit	$ ____________	x	$ ____________	=	$ _____________
Other	$ ____________	x	$ ____________	=	$ _____________

Participation in the Premium Only Plan is strictly optional for all eligible employees. As a plan participant, I understand the following:

- I cannot change or terminate my benefit elections during the Plan Year unless I have a qualified status change, as defined under IRS regulations.
- If the premiums for the elected benefits are changed while this agreement remains in effect, my compensation reduction may be adjusted to reflect that increase or decrease.
- Thirty days before the new plan year, I will be offered the opportunity to change my benefit election. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit coverage already in effect for the new plan year. I may withdraw my participation from the plan only at the end of the plan year.
- The Plan Administrator may modify this agreement, if necessary, in order to satisfy the provisions of the Internal Revenue Code.

Employee Signature ____ Date _______ / _______ / _______

Employer Signature ____ Date _______ / _______ / _______