

**American United Employers, Inc.  
Cafeteria Plan Insurance Election Form**

<input type="checkbox"/>	Correction
<input type="checkbox"/>	Change of personal information
<input type="checkbox"/>	Change of Family Status
<input type="checkbox"/>	Transfer
	Effective Date _____
<input type="checkbox"/>	Termination
<input type="checkbox"/>	Division _____

**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.)

Monthly Employee Cost Per Month	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
				<b>Total Cost Per Month \$ _____</b>

**Salary Reduction Agreement**

I have read and understand the explanation I have received regarding my options under the American United Employers, Inc. Medical Benefit 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 you, your spouse or children; or your dependents 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.

I hereby apply for the options listed above. If necessary, I authorize American United Employers, Inc. 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

**I have been offered and hereby decline this benefit.**

**Signed** \_\_\_\_\_ **Dated** \_\_\_\_\_