LAYMON GROUP
Building Relationships

Premium Only Plan – Employee Enrollment Form

Instructions: Please complete this form and submit it to your Group Administrator.

SECTION I – PERSONAL INFORMATION

2. Employer Name	3. Full-Time Hire Date (Month / Day / Year)

4. Employee Name (Last Name, First Name, MIddle Initial)

5. Social Security Number	6. Birth Date (Month / Day / Year)	7. Marital Status (choose one) ☐ Married ☐ Single ☐ Divorced

8. Employee Mailing Address (Street, City, State, Zip)

	10. Home Phone	11. Work Phone

SECTION II – BENEFIT PREMIUMS

Select Benefit(s)	Benefit	Annual Amount	Monthly Premium	Per Pay Period	Taxable
☐	Health Insurance				
☐	Dental Insurance				
☐	Group Term Life				
☐	Cancer Insurance				
☐	Accident				
☐	AD&D				
☐	Hosp. Indem.				
☐	Other_____				
	Total Premiums:				

SECTION III – AUTHORIZATION / EMPLOYEE SIGNATURE

I understand that:

- This election will remain in effect for the duration of the plan year.
- The Administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
- My employer cannot be responsible for any tax liabilities, which I may incur as a result of my participation in the Plan.
- I cannot suspend, increase or decrease these deductions during the plan year unless I experience a valid change in status.

I authorize payroll deductions for the total amount(s) indicated into my selected Plan Accounts, and certify that I have read this enrollment form.

17. Employee Signature	18. Date
_____	_____