Arkansas State University
ASU MOUNTAIN HOME

Benefit Confirmation / Deduction Authorization

Name		Date of Birth	Home Phone	Work Phone
Jane A. Doe		1/1/1991	(870) 123-4567	(870) 123-4567
Employee ID	**Hire/Elig Date**	**Gender**	**E-mail Address**	
123456	7/9/2013	F		

Address
111 First Street Mountain Home, AR 72653

Location	Department
ASU MOUNTAIN HOME	Default
Job Class	**Title**
Admin	Test Dummy

Reason for Completing Form
<Select reason> on 7/9/2013

Benefit Plan	Option	Cvg	Ded Cycle	Effective Date	Benefit Amount	Requested		Employee Cost		Employer Cost
						Benefit	Cost	Pre-tax	After-tax	
Health Insurance	TrueBlue PPO	FA	24	8/1/2013				119.13	0.00	314.99
Dental Insurance	Dental Blue 01 - Low Option	ES	24	9/1/2013				27.00	0.00	
Vision Plan	Vision Service Plan	EO	24	8/1/2013				3.95	0.00	
Basic Term Life and AD&D	Group Life and AD&D	EO	24	8/1/2013	50000.00					6.75
Dependent Basic Term Life	Spouse Group Life and AD&D	SC	24	8/1/2013	2000.00					0.28
Supplemental Life	Supplemental Life Insurance	EO	24	9/1/2013	100000.00			0.00	4.50	
Supplemental Spouse Life	Spouse Supplemental Life	SO	24	9/1/2013	25000.00	50000.00	2.25	0.00	1.13	
Supplemental Child Life	Child Supplemental Life	CO	24	9/1/2013	10000.00			0.00	1.00	
Supplemental Dependent L	Spouse/Child Supplemental Li	EO	24	9/1/2013	5000.00					
Supplemental AD&D	Supplemental AD&D	FA	24	9/1/2013	100000.00			0.00	3.20	
Short Term Disability	Short-Term Disability	EO	24	9/1/2013	400.00			0.00	14.80	
Long Term Disability	Group Long Term Disability Pl	EO	24	11/1/2013	1750.00					5.10
Health Care FSA	TASC - Medical Reimburseme	EO	24	9/1/2013	450.00			50.00	0.00	
Dependent Care FSA	TASC - Dependent Care Expe	EO	24	9/1/2013	1800.00			200.00	0.00	
Third Party Insurance FSA	Waived									
Long Term Care	Waived									
							Total:	400.08	24.63	327.12

DEPENDENT INFORMATION.

Dependent Name	Relationship	SSN	Birth Date	Gender	Enrollment
John A. Doe	Spouse	987654321	1/1/1991	M	Health Insurance, Dental Insurance, Dependent Basic Term
Jim A. Doe	Child	012345678	1/1/2013	M	Health Insurance, Dependent Basic Term Life and AD&D, S

BENEFICIARY INFORMATION

Beneficiary Name	Relationship	Benefit Plan	Beneficiary Type	Percentage
John Doe	Spouse	Basic Term Life and AD&D	Primary	100.00
June Doe	Parent	Basic Term Life and AD&D	Contingent	100.00
John Doe	Spouse	Supplemental Life	Primary	100.00
June Doe	Parent	Supplemental Life	Contingent	100.00

PAYROLL DEDUCTION AUTHORIZATION/CANCELLATION

By submitting my benefit choices, I acknowledge that I am authorizing my employer to take pre-tax and/or, to the extent relevant, after-tax deductions from my paychecks to pay for my benefit costs. I understand that pursuant to Internal Revenue Code section 125, this election can only be made during the annual open enrollment period before the beginning of each plan year (unless I am a new hire), and is irrevocable for the entire calendar year unless I incur a Qualifying Family Status Change or other permissible mid-year change event, as determined by the Pre-Tax Payment Plan and the underlying benefit plan(s) I have chosen to participate in (collectively, the "Plans").

I understand that the maximum salary reductions I can make are set forth in the Plans, and that the Plans govern all issues concerning my elections, payroll deductions, eligibility, and benefits. I acknowledge that my elections (with the exception of contributions to Reimbursement Accounts) will automatically rollover from year to year unless I submit a change during the annual open enrollment period.

I agree that in the event of any change in the required benefit plan contributions prior to the next enrollment period, my payroll deduction election will automatically be revised to take such change into account. I also understand that my contributions to Reimbursement Accounts, if any, can only be used to reimburse qualified health and/or dependent care expenses incurred in the same year as the contributions are deducted from my paychecks. Any funds remaining in my Reimbursement Account(s) not used for current year expenses will be forfeited after all current year reimbursements are processed. I understand that I may be required to provide Human Resources with proof of dependent eligibility in order to receive coverage for my dependent(s).

Finally, I am also authorizing my employer to use and send necessary personal information, including Protected Health Information under HIPAA, to my selected benefit vendors and providers in order to initiate and support my coverage elections.

Your total deduction per pay period

Total Deduction
$ 424.71

Employee Signature

Date