Franklin Regional Retirement System
Election Form

Employee Name: _____

Initial the desired box for each insurance listed.

Please initial:

Accept or Decline

Group Health Insurance (I have been informed of options and cost) ☐ ☐

I understand if declined, coverage will only be available:

a) If there is a qualifying event (i.e.: loss of coverage through spouse)

b) During an open enrollment period

Basic $5,000 Group Term Life Insurance..... ☐ ☐

I understand if I desire to participate in the Plan at a later date, I may need to provide, at my own expense. evidence of insurability satisfactory to the Boston Mutual Life Insurance Company

Voluntary Group Term Life Insurance..... ☐ ☐

Must first have the basic life.

I understand if I desire to participate in the Plan at a later date, I may need to provide, at my own expense. evidence of insurability satisfactory to the Boston Mutual Life Insurance Company

Dental Insurance (I have been informed of options and cost) ☐ ☐

I understand if declined, will only be available:

a) If there is a qualifying event (i.e.: loss of coverage through spouse)

b) During an open enrollment period

Disability Insurance ..... ☐ ☐

I understand in the event I desire such Insurance at a later date, I may be required to furnish evidence of insurability at my own expenses, and the Insurance Company will have the right to refuse my request. and....

Disability from Social Security is based on total contributions but is only available if I've worked five of the last ten years.

I will not be eligible for ordinary disability, {non- work related disability} through the retirement system unless vested (10yrs.) and payments at that time would be based on retirement factors at that time including age, years of service and compensation calculations.

Deduct my health insurance premium contributions on a pre-tax basis. ☐ ☐

This will result in a reduced Federal and State tax obligation.

Payroll Authorization:

Where I have accepted and applied for an insurance, my employer is authorized to deduct premium payments from my salary as billed and forward the premium amount to the appropriate insurance carrier. Such deductions shall cease upon written notice from me cancelling this authorization or upon termination of the plan.

_____ _____

Signature of Employee Date:

Waiver:

If an insurance plan is declined, I agree I have been offered the opportunity to participate in this voluntary supplemental insurance benefit plan and I have declined. I understand if I should later desire to apply, evidence of insurability may be required.

_____ _____

Signature of Employee Date: