

**SECTION 125
BENEFITS PAYROLL DEDUCTIONS
ENROLLMENT FORM**

EMPLOYEE INFORMATION

Location/Center Name

Employee Number

Employee Name (Last, First, Middle)

Social Security Number

Street Address

Hours Worked per Week

City, State, Zip

PRE-TAX BENEFITS PREMIUM DEDUCTIONS

Listed below are the benefits that may be available please indicate you elect to deduct premiums pre-tax by checking the box.

Health, Dental & Vision

AUTHORIZATION

I authorize Texas Migrant Council to deduct from my regular bi-weekly paycheck my benefits premium co-payments on a pre-tax basis. I understand that by signing and submitting this form I am making a binding election as stated unless such revocation or new election is on account of and consistent with a change in status caused by a Qualifying Event (e.g., marriage, divorce, death, and termination of coverage of spouse). I further understand that this form must be signed and dated prior to my Plan effective date in order to be eligible to participate.

Signature

Date

DECLINATION

The benefits of the plan have thoroughly explained to me and I decline to participate. I understand that I cannot re-enroll until the beginning of the next plan year or until I experience a change in status that would allow me to change my election.

Signature

Date