IPG POP Plan Enrollment Form

For the plan year _____

Company Name _____

PLEASE PRINT

Name: _____ Social Security #: _____

Please mark your choice below:

_____ **Premium Conversion**
I elect to pay the premiums for my employer sponsored insurance through pre-tax salary reduction. I understand that if this amount increases or decreases during the plan year the amount of my salary reduction will be adjusted to reflect the change.

_____ **I do not wish to participate.** I do not elect to have my insurance premiums paid through pre-tax salary reduction.

I understand:

- I cannot change this election during the plan year unless I have a change in family status as defined by the plan.
- My Social Security benefits may be reduced by this election of salary reduction.
- This election replaces any previous elections and will terminate on the earlier of:
  - the end of the plan year
  - the date I am no longer paid compensation at least equal to my total salary reduction
  - termination of the plan.
- My employer may reduce or cancel this election to comply with non-discrimination regulations of the Internal Revenue Code.

Signature: _____ Date: _____

To Be Completed by Employer

Accepted by: _____ Date: _____