HERMANN
TOTAL DISTRIBUTION SERVICE

ENROLLMENT FORM 2017

Employee: _____ Social Security #: _____

Date of Birth: _____ Date of Hire: _____

Address: _____

Division (Please circle) HSI HTS HLC HWC

Choice (Please circle) Single Employee + Child Employee + Spouse Family

Medical Plan Option: (Please circle) HDHP POS Waive

If coverage is waived: Please provide reason and proof of coverage: _____

Dental: (Please circle) Yes No (Dental coverage only applies if you choose to take the medical coverage)

Flexible Spending Account :(Please circle) Health Care Dependent Care Waive

Amount to be deducted from my weekly paycheck: Health Care $_____ Dependent Care $_____

Dependents: Spouse: _____ Must be your current legal Spouse Only

Social Security #: _____ Date of Birth: _____

Date of Marriage: _____

Dependent Children: If you have additional eligible dependents, please attach a separate sheet.

Name: _____ Name: _____

Social Security #:_____ Social Security #: _____

Date of Birth: _____ Date of Birth: _____

Name: _____ Name: _____

Social Security # _____ Social Security #: _____

Date of Birth: _____ Date of Birth: _____

Acknowledgement of Binding Effect of Benefit Elections and Payroll Deductions: I understand that I am making a binding election of my benefits and authorizing any corresponding payroll deductions. I understand that my contributions through payroll deductions are completely voluntary and in compliance with State Law. I cannot change or revoke this salary deduction agreement with respect to pre-tax premiums during this plan year unless the Plan Administrator determines that I have experienced a change in status or other such event that permits a change or revocation under the plan document and the Internal Revenue Code.

Signature: _____ **Date:** _____

Please return this form to your immediate supervisor or the Human Resources Department.