MISSISSIPPI STATE UNIVERSITY
PRE-TAX BENEFIT PLAN ENROLLMENT FORM

NAME:_____ **MSU ID:**_____ **Date of Birth:**_____
ADDRESS:_____
Mailing Address City State Zip

Instructions: **For each coverage selected, please enter the correct semi-monthly premium. If you have premiums under the column labeled "PRE TAX," read the "PRE-TAX ELECTION" section below, sign, and date.**

ELIGIBLE COVERAGES	PRE-TAX	AFTER-TAX
State Employees' Health Insurance Plan	$_____	
State Employees' Life Insurance Plan	$_____	
Delta Dental	$_____	
Davis Vision	$_____	
AFLAC Hospital Indemnity		$_____
AFLAC Accident		$_____
AFLAC Critical Illness with Cancer		$_____
AFLAC Term Life with Long Term Care		$_____
Long Term Care – GENWORTH		$_____
Long Term Disability – UNUM		$_____
Long Term Disability – American Fidelity		$_____
UNUM Term Life Insurance (employee, spouse, and/or children).		$_____

The following products are no longer offered to new employees. Employees who are currently enrolled in these products and need assistance with dropping coverage or have questions about their coverage may contact the MSU Benefits Office, (662)325-3713; located in McArthur Hall Room 150.

-Whole Life (& Riders) - UNUM

-Critical Illness, Cancer (& Riders) - UNUM

PRE-TAX ELECTION

I understand that eligible benefits offered by Mississippi State University are available to me through payroll deduction under the Pre-Tax Benefit Plan as provided under Section 125 of the Internal Revenue Code (IRC). My salary will be reduced by amounts shown above for the benefit option(s) I have elected and I understand that I must complete an application for coverage for each election. I understand pre-tax elections are not eligible as deductions for federal or state income tax purposes and may reduce social security benefits. Elections are irrevocable for the plan year (Jan. 1 – Dec. 31) except for modifications due to qualified status change(s) (divorce, marriage, death of spouse or dependent, birth or adoption of a child, change of employment status of a spouse, or employee/spouse take an unpaid leave of absence). Such changes must be made within 60 days of the status change date. If the elected insurance benefit(s) premiums are increased or decreased, my salary will automatically adjust to reflect the change. Prior to each plan year, I will be given the opportunity to change my benefits election(s). If I fail to complete and return a new election form within the enrollment period preceding each plan year, I understand my election will remain the same. My employer may reduce or cancel the amount of my salary reduction or modify this agreement to satisfy certain provisions of the IRC. I understand my elected benefits will cease upon termination of employment. This election and salary reduction agreement is subject to the terms of my employer's Cafeteria Plan Document.

YES, I WISH TO PARTICIPATE: _____ _____
EMPLOYEE SIGNATURE **DATE**

FOR OFFICE USE ONLY: Pay Period: 24/24___ 18/24___ 18/18___**DATE OF HIRE**:_____
Payroll Effective Date:_____ **STATUS CHANGE**:_____**ELIGIBILITY DATE**:_____