BIGREDF RESTAURANT GROUP

Big Red F

Premium Only Plan Enrollment Form

January 1, 2017

Employee Name:_____

Employee Social Security Number: _____

☐ I hereby elect to participate in the Premium Only Plan and to have my salary reduced by my medical, dental, and/or vision insurance premiums. The per pay period deduction amounts will be withheld on a pre-tax basis. I understand that once I am a participant, I cannot change my deduction amounts during the Plan Year unless a qualifying event occurs.

☐ I hereby elect not to participate in the Premium Only Plan for this year. I understand I will not be able to change my election until the following plan year, unless a qualifying event occurs.

_____ _____

Employee's signature Date