

LEVEL1	LEVEL 2	EMPLOYEE NUMBER ★
IN	SP	SS#

LAST NAME *	FIRST NAME*	MIDDLE NAME/INITIAL	•
STREET ADDRESS *	CITY *	STATE *	ZIP CODE ★

PLEASE READ BELOW IF YOU ARE ELECTING HEALTH AND/OR BASIC LIFE INSURANCE

You must enter the word "NO" in the TAXSAVER box below if you <u>DO NOT</u> wish to participate in the TaxSaver Plan. Leaving this box blank will automatically enroll you in the 125 TaxSaver Plan. (Consult your payroll clerk regarding your TaxSaver eligibility for Basic Life Insurance.)

START	CHANGE	STOP	TAXSAVER (NO ONLY)	DOE CODE	METHOD CODE	PERIOD CODE	TYPE CODE	\$ AMOUNT % PERCENT	LIMIT	DOE DESCRIPTION
Χ				S1	1	Α	N	0001100	N	ISPA
									N	
									N	
									N	
									N	
									N	
									N	
									N	
									N	
									N	
									N	
									N	
									N	
									N	
									N	
									N	
I here autho	by author	rize my hall ren	employer t	to dedu force ui	ct from n	ny pay ean	ach pay my emp	day for purpos	e(s) indicated of til cancelled by	on this form. This me in writing.
SIGNATU	IRE OF EMPLO	DLYEE							DATE SIGNED (Month,	Day, Year)