EBS Employee Benefit Services, Inc.
Personal Election Form, Issue Date: 09/12/2006

Acme, John R
123 Acme Ln
San Antonio, TX 78228
210-555-5555

AAA Acme
4318 Woodcock Dr., Ste. 130
San Antonio, TX 78228

Employment Date:	01/01/2001	Effective Date:	01/01/2004
SSN:	123-45-6789	Gender:	M
Occupation:	President/CEO	DOB:	06/06/1966
Marital Status:	M	Salary:	$66666
Level:	1	Pay Period:	24
Location:		Medical Effective:	/ /

Medical - EBS - Grp #: AAA0102

Election	Description	PPD
A	Employee Only	$0.00
B	Employee & Child(ren)	$63.88
C	Employee & Spouse	$88.88
D	Employee & Family	$113.88

Option Elected: __________

Dental - EBS - Grp #: AAA0102

Election	Description	PPD
A	Employee Only	$0.00
B	Employee & Family	$15.00

Option Elected: __________

This medical plan has a 12 month pre-existing condition exclusion which starts with your date of hire and which may be offset by your HIPAA Certificate showing prior creditable coverage. You have the right to request a certificate from a prior plan and may receive help from this plan in obtaining said certificate. DO YOU HAVE A HIPAA CERTIFICATE showing prior coverage? YES ___ NO ___

Are you or your dependents covered under another group plan? YOU: YES ___ NO ___ DEPENDENTS: YES ___ NO___

The self-insured plan administered by EBS, Employee Benefit Services, Inc. has the following provisions:

1. Limited Enrollment Period: After January 1, 2002, you will not be allowed to change your elections until December 1, 2002 for a January 1, 2003 effective date, unless you experience a Family Status Change or qualify for a Special Enrollment Period.
2. Special Enrollment Rules: If you decline enrollment for you or your dependents because of other health insurance coverage, you may later enroll yourself or your dependents provided you request enrollment within thirty days after your other coverage ends. Further, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents, provided that you request enrollment within thirty days after that event.
3. By signing you allow EBS Employee Benefit Services, Inc. to subrogate against an at fault third party's liability carrier.

SIGNATURE ____ DATE ____________________

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Employee Term Life - ABC Insurance Co.

Election		Description	PPD
A	$50000	Base Life/AD&D Insurance	$0.00
B	$50000 + $67000	Additional Life/AD&D Insurance	$5.36
C	$50000 + $134000	Additional Life/AD&D Insurance	$10.72
D	$50000 + $200000	Additional Life/AD&D Insurance	$16.00
E	$50000 + $267000	Additional Life/AD&D Insurance	$21.36

Option Elected: __________

Spouse Life - ABC Insurance Co.

Election		Description	PPD
A		Waive Spouse Life Coverage	$0.00
B	$25000	Spouse Life Coverage	$3.13

Option Elected: __________

Child Life - ABC Insurance Co.

Election		Description	PPD
A		Waive Child(ren) Life Coverage	$0.00
B	$5000	Child(ren) Life Insurance	$0.38

Option Elected: __________

* Employee Term Life amounts in excess of $150,000 (Base + Optional) will be subject to evidence of insurability.
* Life insurance amounts will reduce by 35% @ age 65, by 50% @ age 70, and by 65% @ age 75.
* Life insurance will terminate upon retirement.
* Employee Term Life includes Accidental Death & Dismemberment.
* Insurance will be delayed if employee is not actively at work on effective date.
* Insurance will be delayed if a dependent is totally disabled on the date that insurance would be effective.

Please list the individual(s) you wish to recieve the proceeds of your life insurance.

	First Name	Last Name	Relationship	Pct.
Primary Beneficiary	__________	__________	__________	______%
Primary Beneficiary	__________	__________	__________	______%

If your primary beneficiary(ies) are not living when you die, list the individual(s) you wish to recieve the proceeds.

Contingent Beneficiary	__________	__________	__________	______%
Contingent Beneficiary	__________	__________	__________	______%

SIGNATURE ______________________________ DATE ______________

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Voluntary STD - ABC Insurance Co.

Election		Description	PPD
A		Waive STD Coverage	$0.00
B	$500	Weekly Benefit	$12.50

Option Elected: __________

Voluntary LTD - ABC Insurance Co.

Election		Description	PPD
A		Waive LTD Coverage	$0.00
B	$3334	LTD Monthly Benefit	$13.89

Option Elected: __________

List your dependents here. Please list expected graduation date(s) for children 19 years & over.

Dependent Name		Birthdate	Gender	Social Security Number	Graduation Date
SPOUSE	______________________	___/___/_____	M F	___-__-____	___/___/_____
CHILD 1	______________________	___/___/_____	M F	___-__-____	___/___/_____
CHILD 2	______________________	___/___/_____	M F	___-__-____	___/___/_____
CHILD 3	______________________	___/___/_____	M F	___-__-____	___/___/_____
CHILD 4	______________________	___/___/_____	M F	___-__-____	___/___/_____

_____ I hereby authorize a reduction in my salary in accordance with my election(s) under the Flexible Benefit Cafeteria Plan as adopted by my employer.

_____ I do not authorize a reduction in my salary in accordance with my election(s) under the Flexible Benefit Cafeteria Plan as adopted by my employer.

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