

Pre-Tax Premium Notification

Notice of Hiring, Termination, or Changes Affecting Pre-Tax Premiums

This form collects accurate information about the pre-tax insurance premium payments by all employees, to reflect this information in periodic discrimination testing.

Please Submit Promptly to **ProBenefits** – Fax (877) 761-1850

Company/Organization: _____

Name of Participant: _____ Date of Notice ___/___/___

Social Security # : _____ Date of Birth: ___/___/___ Date of Hire ___/___/___

1. Insurance Premium Information

Action(1)	Coverage(2)	EE Paid* (3)	ER Paid*(4)	Comments
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____

(1) Action Enter **A=Add** a Coverage, **C=Change** a Coverage, **D=Drop** a Coverage

(2) Coverage Enter coverage type, such as Medical, Dental, etc.

(3) EE Paid Enter the Employee paid portion of the Premium Indicate Frequency

(4) ER Paid Enter the Employer paid portion of the Premium

* Please indicate frequency of amount (**M**onthly, **Bi**Weekly, **S**emi-Monthly, **W**eekly, **48X**/yr.)

2. Reason for Action

- New Employee now eligible for insurance Date Insurance Begins ___/___/___
- Employee Termination ___/___/___ Date Insurance Ends ___/___/___
 - Health insurance continuation coverage (COBRA or state continuation coverage) was pre-paid from final paycheck on a pre-tax basis in the amount of \$_____.
- Other (Please Explain) Date Effective ___/___/___

3. Comments

4. Certification by Employer Administrator

Signature _____ Date ___/___/___

Printed Name _____

Please submit promptly to **ProBenefits** – Fax (877) 761-1850