

HEALTH INSURANCE PREMIUM PRE-TAX ELECTION

I, _____, elect to participate in the Putnam County

Please Print Name

FSA Program.

I understand that participation in this program is voluntary and will allow

my health insurance premiums to be deducted on a pre-tax basis.

I agree to have health insurance premiums deducted from my gross salary before taxes are applied, thereby reducing my taxable income. This will not affect my insurance coverage in any way.

Signature

Title

Department

Date

HEALTH INSURANCE PREMIUM PRE-TAX DECLINATION

I, _____, elect NOT to participate in the Putnam County

Please Print Name

FSA Program.

I understand that by not participating in this program, my health insurance premiums will
be deducted on a post-tax basis

and the premiums will not reduce my taxable income. This will not affect my insurance coverage in any way.

Signature

Title

Department

Date