

HEALTH INSURANCE COSTS FOR

 Contract Employee's Name

During my contractual period from _____ to _____
 Date Date

I will be enrolled in the following health insurance plan(s):

Health Plan _____ \$ /month
 (Vision coverage included in health plan)

Check Level of Coverage:
 Employee Only _____
 Employee & One Dependent _____
 Employee & Two or More Dependents _____

Prescription Plan _____ \$ /month

Check Level of Coverage:
 Employee Only _____
 Employee & One Dependent _____
 Employee & Two or More Dependents _____

Dental Plan _____ \$ /month

Check Level of Coverage:
 Employee Only _____
 Employee & One Dependent _____
 Employee & Two or More Dependents _____

TOTAL FOR 12-MONTH CONTRACT PERIOD: \$ /month

Signature of Employee Date