



ELECTION OF INSURANCE BENEFITS

As an employee of Allegiant Management Corporation, you have the opportunity to choose from several different insurance benefits.

Please complete this form to either receive further information for the purpose of electing insurance coverage or to decline insurance benefits.

NAME: _____ (first) (Middle) (Last)
ADDRESS: _____ _____
SOCIAL SECURITY NO. _____
CLIENT COMPANY: _____
YES - I would like information on the following coverage's <small>(please circle)</small> _____ MEDICAL _____ VISION _____ DISABILITY _____ DENTAL _____ LIFE
NO - I decline all benefits and by doing so, I understand that I <small>(please circle)</small> am not eligible to apply again until open enrollment:
SIGNATURE: _____ DATE: _____

**Failure to submit this form upon your hiring,
may make you ineligible to obtain insurance coverage
until the next open enrollment period.**