

BIC U.S. 403(b)(9) Plan Enrollment Form



A. Employee and Employer Information:

Name of Employee: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____ Date of Hire: _____

Name of Employer: _____

Full time employee: Yes ___ No ___ Position/Title: _____

If not Full time, average number of hours worked per week: _____

Paid hourly or salary: _____

B. Your Authorization:

I understand the provisions of the Plan and elect to participate in the Plan through employee and/or employer contributions.

Signature: _____

Date: _____

Once this form is completed, signed, and dated, please retain a copy for your records, send the original copy to your employer.