U. S. Restaurants, Inc. Medical Plan

VOLUNTARY CANCELLATION OF EMPLOYEE CONTRIBUTIONS FOR MEDICAL COVERAGE

(Please Print)

NAME:_____

HOME ADDRESS:_____

_____

SOCIAL SECURITY #:_____ **UNIT #:**_____

To The Human Resources Department:

I hereby provide notification that I refuse to make contributions for my medical coverage through my employer's Section 125 Premium Plan. I understand all coverage for myself, and any covered family members, will cease as soon as practicable, after your receipt of this form. I also understand, according to IRS regulations, I will not be permitted to re-enroll in the plan for the remainder of the plan policy period.

_____ _____

Signature of Employee **Date**

_____ _____

Authorized Representative **Date Authorized**