

**AGENCY FOR PERSONS WITH DISABILITIES**  
**ENROLLMENT FORM FOR THE HYATT LEGAL PLANS**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ People First ID Number: \_\_\_\_\_ Home Zip Code: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Work Location: \_\_\_\_\_

*I wish to ACCEPT enrollment into the HYATT LEGAL PLANS and authorize, now or hereafter, the appropriate deductions be taken from my wages for this Plan. I understand my enrollment in the HYATT LEGAL PLANS is effective for one full year, and cannot be canceled during that period.*

Employee's Signature (Required for Processing): \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN TO YOUR POST TAX BENEFITS COORDINATOR

PREMIUM TO BE DEDUCTED: \$8.20

HYATT LEGAL PLANS

MISC. DEDUCT. CODE: 257