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

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premium to Be Deducted: $7.62 - biweekly　　Hyatt Legal Plans　　Misc. Deduct. Code: 257