

**MILITARY RESERVIST CALLED TO ACTIVE DUTY**

NAME: \_\_\_\_\_

DEPLOYMENT DATE: \_\_\_\_\_

SERVICE BRANCH: \_\_\_\_\_ RANK/GRADE \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

**BENEFIT PACKAGE:**

Please indicate whether or not you would like to continue with your current coverage elections:

|                              | Yes   | No    |
|------------------------------|-------|-------|
| Health                       | _____ | _____ |
| Optional Dental              | _____ | _____ |
| Employee Life Insurance      | _____ | _____ |
| Dependent Life               | _____ | _____ |
| Vision                       | _____ | _____ |
| Long Term Care               | _____ | _____ |
| Medical Reimbursement Acct   | _____ | _____ |
| Dependent Care Reimbursement | _____ | _____ |

If you elect to continue with your current coverage, you will be responsible to pay any premium amount over the State contribution. Please complete the attached Authorization Agreement for Direct Payments and return with this form.

**Power of Attorney Information**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_

To any armed forces employer: I authorize you to release to the State of Wyoming all the information contained in my earnings statement. I understand that the State of Wyoming will use this information to determine my eligibility for salary mitigation.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Agency \_\_\_\_\_

Please attach a copy of your orders to this form. **Also, forward a copy of your first leave and earnings statement as soon as possible to begin compensation mitigation.**

|   |       |
|---|-------|
| <b>For State of Wyoming use only:</b>       |       |
| <b>COMPENSATION MITIGATION COMPUTATION:</b> |       |
| Current State Base Salary                   | _____ |
| Military Base Salary                        | _____ |
| Compensation Change                         | _____ |