Classified Active Employee

Section 125 Plan: Enrollment Form and Salary Reduction Agreement

ENROLLMENT INFORMATION

(Please print)

Name: _____ _____ _____ _____
(Last) (First) Middle Initial Date of Birth

_____ Phone: _____ _____
Social Security Number (Area Code)

_____ _____ _____
Street Address (City) (Zip)

I understand that the District will contribute to my Section 125 Plan Account a monthly amount equal to 3-tiered Kaiser rate and the District portion of the dental/vision based upon my coverage status as described in the SEIU and Teamster contracts and currently calculated as follows: **Rates listed are 12thly deductions are prorated according to each work-vacation group.**

I agree that the District shall deduct monthly from my Account the following amounts:

◆ **PERS Health Plan Premium for the plan in which I have enrolled.**

☐ I do not elect Health coverage **(waiver must be completed yearly)**

☐ I elect the Health Plan as specified on the CalPERS form

_____ $ _____
Name of selected Plan Monthly deduction

◆ **Dental/Vision/Life If health coverage selected, Dental/Life must match level of health coverage.**

☐ I do not elect coverage

☐ I elect Dental/Vision/Life coverage for myself and dependents $ _____
Monthly deduction

Name	SSN#	Date of Birth	M/F	Relationship

(Use back for additional dependents)

I authorize the District to reduce my salary by an amount equal to, if any, the amount my choices exceed my monthly Account contribution. I understand that if my choices are less than my monthly Account contributions no money will be returned to me.

I understand that I may not change my elections for these accounts during the Plan year (January – December) except under circumstances allowed by law (i.e., termination of employment, marriage, divorce, spouse's employment terminates, upon the death of my spouse or child or other eligible dependent).

I understand that the selections made herein shall be automatically renewed each calendar year (January - December) until such time as I elect to change my coverage during CalPERS annual open enrollment periods.

_____ _____
Signature Date

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