Healthcare Contributions Only Plan: Salary Reduction Agreement

Employee information

Name _____ **Last 4 digits of SSN** _____

Address _____

City _____ **State** _____ **ZIP code** _____

Daytime phone (_____) _____ **Email** _____

Reason for election (check one):

☐ Annual enrollment election ☐ New employee enrollment ☐ Qualified life event

Effective date: _____ (completed by employer)

Salary reduction for employee contributions

I elect to participate in the Healthcare Contributions Only Plan and authorize my employer to withhold from my paycheck the required contribution towards my dues share for healthcare coverage.

Acknowledgment, acceptance, and signature

I acknowledge that I have received the Healthcare Contributions Only Plan (the "Plan") document from my employer and I understand and accept the following terms and conditions:

- By completing and signing this form, I am authorizing my employer to withhold wages from my salary to pay my share of healthcare coverage I have elected.
- This authorization will continue in effect for as long as I am enrolled for healthcare coverage, unless I change my election during annual enrollment or I notify my employer and the Board of Pensions in writing of coverage changes due to a qualifying life event (as defined in the Plan document).
- I understand that these enrollment elections and my authorization to withhold my contributions cannot be changed except during annual enrollment or upon a qualifying life event.
- I am responsible for initiating any change in my elections due to a qualifying life event, as described under the Plan, within 60 days of such event.

Employee's signature (*required*) _____ **Date** _____