Salary Reduction Authorization/Waiver Form

INSTRUCTIONS: Please fill out the "Employee Information" section, check the appropriate box, print your name on the line, sign and date the form and return to Human Resources.

EMPLOYEE INFORMATION	PLEASE PRINT!

Name:

PLAN ENROLLMENT

I elect to participate in one of the High Deductible Health Plans with Health Savings Account and I agree that my annual cash compensation will be reduced by the weekly contribution amounts (on a pre-tax basis) for the health benefit plan.

Please check the line that applies to your coverage.

COVERAGE LEVEL	OPTION 1	OPTION 2
Employee Only	☐ $15.00	☐ $50.00
Employee/Child(ren)	☐ $35.00	☐ $90.00
Employee/Spouse	☐ $85.00	☐ $160.00
Family	☐ $95.00	☐ $170.00

If you are making changes to your HSA amount or enrollment status, you must also complete a HSA election form and/or Enrollment/Change form.

HEALTH SAVINGS ACCOUNT (HSA)

I would like to contribute $ _____ per pay period ($ _____ annually) to my HSA for the upcoming calendar or the remainder of the current year.

PLAN WAIVER

I **DO NOT** WISH TO ENROLL FOR MEDICAL BENEFITS AS OF THE FOLLOWING EFFECTIVE DATE:_____.
I AM CURRENTLY COVERED UNDER THE FOLLOWING MEDICAL PLAN: _____.
CARRIER: _____GROUP NUMBER: _____

☐ Self ☐ Dependent(s)

I **DO NOT** WISH TO ENROLL FOR PRESCRIPTION DRUG BENEFITS AS OF THE FOLLOWING EFFECTIVE DATE: _____. I AM CURRENTLY COVERED UNDER THE FOLLOWING PRESCRIPTION DRUG PLAN_____.
CARRIER: _____GROUP NUMBER: _____

☐ Self ☐ Dependent(s)

I understand that if I am enrolling in or waiving medical and/or prescription drug benefits, I cannot change this election until the next Open Enrollment period, unless I experience a qualified change in status (e.g., termination of employment, divorce, marriage, etc.). Also, the election change must be on account of and consistent with the change in election event, as described in the Plan. Additionally, I agree that I was given the opportunity to enroll in the group health benefits plan offered by my employer and I understand that, if waiving coverage, I will have no health benefits coverage available to me (and my children and/or spouse, if any) through my employer health plan.

Furthermore, I understand that it is my responsibility to notify and submit the required supporting documentation to Human Resources within 31 days of experiencing a qualified change in status.

I have read and agree to the terms of my enrollment or waiver set forth in this agreement. Any previous election and agreement under the Plan relating to the same benefits, including any prior election form/salary reduction agreement, is hereby revoked.

PRINT NAME SIGNATURE DATE

FAILURE TO RETURN THIS FORM COULD IMPACT ELIGIBILITY FOR HEALTH BENEFITS