LAST NAME: _____ FIRST NAME: _____

Madison Public Schools
NAGE SALARY REDUCTION AGREEMENT AND SELECTION OF BENEFITS
(Rates Effective 9/01/16)

I agree to have my gross salary reduced in accordance with Section 125 of the Internal Revenue Code. I understand that my benefit contribution dollars are not subject to FICA, Federal or State income taxes. These monies will be used to cover my contribution toward the benefits listed below. This agreement will remain in effect until my employment terminates, a qualifying change occurs, (e.g., marriage, divorce, death of spouse or dependent, spouse loses or obtains a job, reduction in hours, unpaid leave of absence for you or your spouse, birth or adoption of a child, etc.), my benefits change at the beginning of a new plan year, or my employer terminates, suspends or modifies the plan.

The 2016/17 rates listed below apply to the 2016/17 school year only.

Please check the plan and the level of coverage desired, and return this form to the Human Resources Department.

☐ **I elect to participate in the Anthem Blue Cross Blue Shield Century Preferred Plan.**
☐ **This is a change from my current plan / coverage level.**

The cost of the medical co-pay (10 months, 20 pay periods):	Single:	$ 78.30	☐
	Two Person:	$168.35	☐
	Family:	$211.41	☐
Dental co-pay (10 months, 20 pay periods):	Single:	$ 3.89	☐
	Two Person:	$ 25.70	☐
	Family:	$ 52.87	☐

-OR-

☐ **I elect to participate in the Anthem Blue Cross Blue Shield High Deductible Health Plan (HDHP)**
☐ **This is a change from my current plan / coverage level.**

The cost of the medical co-pay (10 months, 20 pay periods):	Single:	$ 60.62	☐
	Two Person:	$130.28	☐
	Family:	$163.47	☐
Dental co-pay (10 months, 20 pay periods):	Single:	$ 3.89	☐
	Two Person:	$ 25.70	☐
	Family:	$ 52.87	☐

I understand the above agreement and have selected a health benefit plan accordingly:

Employee name (please print) Employee Signature Date

For Office Use Only

Processed by: _____ Date: _____