LAST NAME: _____ FIRST NAME: _____

Madison Public Schools

TEAMSTERS SALARY REDUCTION AGREEMENT AND SELECTION OF BENEFITS (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 2016/2017 rates listed below apply to the 2016/2017 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 High Deductible Health Plan.**
☐ **This reflects a change from my current plan and/or coverage level.**

The cost of the medical co-pay (10 months, every pay period):	Single:	$ 54.89	☐
	Two Person:	$117.96	☐
	Family:	$147.93	☐
Dental co-pay (10 months, every pay period):	Single:	$ 3.56	☐
	Two Person:	$ 25.37	☐
	Family:	$ 52.65	☐

If you, the employee, are currently enrolled in Medicare or Veterans Benefits, please complete your plan selection below:

Pursuant to the provisions of the Teamsters bargaining agreement, the district will reduce your medical payroll cost-share up to the amount of deductible contribution provided to non-Medicare enrolled employees.

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 High Deductible Health Plan.**
☐ **This reflects a change from my current plan and/or coverage level.**

The cost of the medical co-pay (10 months, every pay period):	Single:	$ 4.89	☐
	Two Person:	$ 17.96	☐
	Family:	$ 47.93	☐
Dental co-pay (10 months, every pay period):	Single:	$ 3.56	☐
	Two Person:	$ 25.37	☐
	Family:	$ 52.65	☐

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: _____