Glenwood City School District * Premium Only Salary Reduction Agreement

Employee Name (Last, First, MI) (Please Print)		Social Security No.
20 Payrolls		Teachers
No. of Deduction Periods	Birth Date	Group

Employee Street Address	City	State	Zip Code

I hereby authorize and direct Glenwood City School District (hereafter "employer") to reduce my salary in the amount necessary to pay for the coverages shown below. Such reductions, considered as elective contributions under the plan shall commence with my paycheck dated 09/08/2017. I further authorize future adjustment in the amount of salary reduction in the event that the cost of coverage in any program selected below under the heading "Premium Conversion" is changed during the plan year.

I understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per-deduction-period cost and the amount to be paid by salary reduction. The selection will remain in effect until a subsequent election form is filed, in accordance with the plan.

BENEFIT	Pre-Tax Deduction for Insurance Premiums
Premium Conversion: $2,600/$5,200 DEDUCTIBLE	
Health – Health Partners – Single Coverage – 12.6% premium paid by employee	$ 87.19
Dental – Single Coverage (Same as Health Insurance)	$ 3.83
Life/LTD -- Individual coverage provided by the District	$ _____
Other - WRS @ 6.80%	$ _____
HSA - $2100.00 provided by District	$

- I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances separate enrollment in health insurance must also be completed.

_____ **This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of a child, Termination of employment of spouse, etc., as listed in the Employer's Plan Document).**

_____ **I understand that the insurance claim payments under certain coverages may be subject to federal and state taxes when the premium is paid by salary reduction or employer contributions.**

Signature:_____ **Date:**_____

IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline to participate.

Signature: _____ **Date:**___/___/___