LEDYARD BOARD OF EDUCATION – OPEN ENROLLMENT FORM
Administrators – Plan #224

EMPLOYEE: **HIRED:**
EMP NO: **DOB:**
ADDRESS : **PLAN YEAR:** **7/1/16 to 6/30/17**
LOCATION:

Here is your Open Enrollment form for 2016-17. Please check the boxes and/or fill in the amounts next to the benefit options you have selected. Once you have chosen your benefits, you can determine your total tax exempt deductions.

HEALTH & DENTAL INSURANCE		
	2016-17 Rate (20 Pays)	**2016-17 Election (Check One Box)**
LUMENOS with Dental/Vision		
Employee Only	**$84.93**	_____
Two People	**$171.62**	_____
Family	**$234.46**	_____
Dental Insurance Only		
Employee Only	**$4.79**	_____
Two People	**$11.25**	_____
Family	**$14.08**	_____
HSA		
HSA Deduction Amount (20 Pays)		**$_____**
Employees may contribute an amount to their HSA through payroll deduction up to the IRS limit. Please review the maximum amounts below.		
	Under 55	**Over 55**
Max Single	**$117.50**	**$167.50**
Max Dual/Family	**$237.50**	**$287.50**

HEALTH INSURANCE WAIVER

I choose not to participate and/or elect health coverage through Ledyard Public Schools, as I currently have health insurance available through an alternate provider. Reimbursement is only open to those contractually eligible.	**Single_____** **Dual _____** **Family_____**
Insurance Company:	
Policy Number:	

REIMBURSEMENT ACCOUNTS	
	2016-17 Amount
FSA - DEPENDENT CARE ($5,000 max)	
Max: $250.00 Single/Married Filing Jointly $125.00 Married Filing Separately	_____
FSA – Limited Purpose Medical Care ($2,550 max) used w/HDHP	
Min.:$10 Max. : $127.50	_____
EMPLOYEE PRE-TAX DEDUCTION SUMMARY	
Medical /Dental Plan Option	_____
Dental Only Plan Option	_____
FSA - Dependent Care Option	_____
FSA – Limited Purpose Option	_____
HSA Deduction	_____
Total Pre-Tax Deductions	_____
Post Tax Deductions:	
Life Insurance ($50,000)	_____
Disability Insurance	_____
Total Post-Tax Deductions	_____

I have read the summary plan description of the medical and flexible benefit plans and choose the benefits indicated on this form. I will stay with the benefit plans I have chosen until the next open enrollment or until I have a qualifying event which permits me to change my elections. I authorize my employer to adjust my paycheck to purchase the benefits indicated above.

Signature:_____ **Date:**_____