

**LEDYARD BOARD OF EDUCATION – OPEN ENROLLMENT FORM
Custodians Plan #232**

EMPLOYEE:
EMP NO:
ADDRESS:

HIRE:
DOB:
PLAN YEAR: 7/1/14 to 6/30/15
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)
Century Preferred plus Dental – Full Year		
Employee Only	\$88.67	
Two People	\$189.34	
Family	\$252.90	
DENTAL INSURANCE only		
Employee Only	\$3.84	
Two People	\$9.01	
Family	\$11.01	

REIMBURSEMENT ACCOUNTS	
	2016-17 Amount
FSA - DEPENDENT CARE (\$5,000 max)	
Max: \$250.00 Single/Married Filing Jointly; \$125.00 Married Filing Separately	_____
FSA - MEDICAL CARE (\$2,550 max)	
Min. :\$10.00 Max. : \$127.50	_____

EMPLOYEE PRE-TAX DEDUCTION SUMMARY	
Medical/Dental Plan Option	_____
Dental Only Plan Option	_____
FSA - Dependent Care Option	_____
FSA - Medical Care Option	_____
Total Pre-Tax Deductions	_____

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: _____

I have read the summary plan description of the flexible benefit plan and choose the benefits indicated on this form. I will stay with the benefit plans I have chosen until 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:** _____