LEDYARD BOARD OF EDUCATION – OPEN ENROLLMENT FORM
Non Union – Plan #309

EMPLOYEE:
EMP NO:
ADDRESS:

HIRED:
DOB:
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		
Employee Only	**$88.44**	_______
Two People	**$178.53**	_______
Family	**$243.74**	_______
DENTAL INSURANCE only		
Employee Only	**$4.49**	_______
Two People	**$10.55**	_______
Family	**$12.88**	_______
HSA		
HSA Deduction Amount (20 Pays)		**$_______**
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**
Life Insurance $100,000 (Not Pre Tax)		
Employee only $ 3.78 per paycheck		_______
Long Term Disability (Not Pre Tax)		
Employee only, calculated on base salary: (Salaryx60%x.0068x.19)/20		_______

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 with 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 Medical Care	_______
Total Pre-Tax Deductions	_______
	_______
Post Tax Deductions	_______
Life Insurance ($100,000)	_______
Long Term Disability	_______
Total Post 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 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:**______________________________