LEDYARD BOARD OF EDUCATION – OPEN ENROLLMENT FORM

Secretaries – Plan #202

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 you 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		**(20 Pays)**
Employee Only	**$87.44**	______
Two People	**$186.70**	______
Family	**$249.34**	______
DENTAL INSURANCE only –		**(20 Pays)**
Employee Only	**$4.07**	______
Two People	**$9.56**	______
Family	**$11.68**	______
Long Term Disability (Not Pre Tax) Check Box		
Employee Only. Employee share is 15% of premium. Calculated on base salary (Base Salaryx60%x.0068x.15/20)		______

REIMBURSEMENT ACCOUNTS	
	2016-17 Amount
FSA - DEPENDENT CARE ($5,000 max)	
Max: $250.00 Single/Married Filing Jointly $125.00 Married Filing Separately	______
FSA - MEDICAL CARE ($2,550 max)	
Min.:$10.00 Max. : $127.50	______
EMPLOYEE PRE-TAX DEDUCTION SUMMARY	
Medical Plan Option	_______
Dental Only Plan Option	_______
FSA - Dependent Care Option	_______
FSA - Medical Care Option	_______
Total Pre-Tax Deductions	_______
Post Tax Deductions:	
Long term Disability	_______

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:**_________________________