# PRETAX PREMIUM PLAN ENROLLMENT

☐ I elect to participate in the Pretax Premium Plan offered by Chesapeake Public Schools for my medical and/or dental premiums. ***(Not an option if waiving medical and taking Dental Employee only)***

☐ I do not elect to participate in the Pretax Premium Plan

Name: _____

SSN: _____

Signature: _____ Date: _____

I understand and agree the amount of premium not covered by School Board contribution will be deducted from my pay before federal, state, and Social Security taxes are withheld. I understand these contribution amounts are irrevocable during the plan year, unless I experience a change in family status as described in the next paragraph. I also understand I may make a new election each year during open enrollment that will be effective October 1st of that same plan year. **My premium contributions have been explained to me and are available on a separate sheet.**

**Changing Coverage**

I understand I may not change my coverage under this plan and my contribution for such coverage (*except October 1st of each year)* unless I experience a change in family status *(i.e. marriage or divorce; or other dependent changes, such as birth or maturity of a child; and dependent losing or gaining employment or insurance.)* If a change in family status occurs, new plan coverage or contributions must be elected **within 31 calendar days of the qualifying event. It is the responsibility of the employee to contact the Financial Services Department within 31 calendar days from the date of the family status change and provide proof of a family status change.**

**Continuing Commitment**

Prior to October 1st of any year, I will be notified of any changes in coverage and/or required contributions. In the event I do not elect to change healthcare plan coverage as of October 1st of any year, this form shall be deemed to continue in force for any succeeding plan year *(October 1st – September 30th)* based on the applicable coverage and contributions at that time.

# PRETAX PREMIUM PLAN CANCELLATION

☐ I elected to participate in the Pretax Premium Plan during the previous year. **Please cancel my participation in the Pretax Premium Plan.**

Name: _____

SSN: _____

Signature: _____ Date: _____

For office use only: Date Received: _____ Effective Date: _____