

TEMPLE CITY UNIFIED SCHOOL DISTRICT
TCEA
EMPLOYEES BENEFIT SELECTION SHEET
January 1, 2015 – December 31, 2015

WAIVE MEDICAL BENEFITS

I wish to waive Medical Insurance

Signature _____

Date _____

Company name I'm presently insured with _____

Subscribers name _____

Subscribers Social Security Number _____

OUT OF POCKET COSTS

Total premium per month \$ _____ X 12 equals annual premium of \$ _____

Less District contribution \$ 9,000 \$ ~~7500.00~~ **8250**

Annual out of pocket \$ _____

Monthly out of pocket for 10 months \$ _____

I hereby authorize the Temple City Unified School District to deduct out of pocket costs from my pay warrants.

Signature _____ Date _____

SECTION 125

I wish to participate in the Section 125 plan for my out of pocket expenses.

Terms and Conditions

I hereby authorize the above payroll reductions as my contribution to my Employer's Section 125 Cafeteria Plan. I understand that:

1. Changes in the cafeteria plan elections (other than with respect to the Health Savings Account) can only be made at the end of the plan year unless due to and consistent with a valid status change (e.g., change in legal marital status, change in number of dependents, change in employment status; dependent satisfies or ceases to satisfy dependent eligibility requirements; residence change, cost of coverage changes) and such other events as would permit a revocation or change of election under IRC 125 regulations. Participation in this plan will automatically cease upon termination of employment. In most cases NO change can be made in the Medical Expense Reimbursement Account except termination of participation of employment. For special rules affecting your plan, please contact your employer. FICA taxes are not paid on Section 125 salary reductions. Therefore, your social security benefits at retirement may be reduced. Unused funds remaining in the flex spending accounts at the end of the current plan year will be forfeited.
2. Execution of this benefit election/salary reduction agreement does not automatically institute insurance coverage; in most instances an application for insurance must be completed. Premiums charged for insurance coverage may be adjusted by the carrier issuing the contract and my "take-home" pay may be higher or lower depending on the selections made.

If you have elected the Health Savings Account benefit, I certify that I have met all the Health Savings Account eligibility requirements, which have been separately disclosed to me, and that I will notify the Employer immediately in writing if I cease to meet any of the conditions for Health Savings Account eligibility during any month of the plan year.

This authorization replaces any previous authorization I have made.

Signature

Notice of Special Enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Sharon Chinn in the Personnel Office at (626) 548-5123.