Lakeland School District

2018 Flexible Benefits Plan
Enrollment Form

*** IMPORTANT NOTE: Employees newly electing or changing insurance coverage MUST complete the corresponding insurance application ***

Name: _____
Please Print Clearly

Last 4 Digits of Social Security Number: XXX—XX—_____

Home Mailing Address: _____

HEALTH INSURANCE

In waiving coverage, I understand that I am waiving health insurance coverage offered by LSD for the full twelve (12) month period of the Plan Year.

[ ] Waive Coverage *

Proof of Alternative Health Insurance Coverage (Insurer, Contract Holder's Name, Member ID):

_____

_____

Waive Health Insurance Coverage: *Annual cash amount paid to employees for waiving health coverage for a full plan year (July-June):*

Coverage	*Amount*
SINGLE:	[ ] $ 4,608.72
EMPLOYEE & SPOUSE:	[ ] $11,599.08
PARENT & CHILD:	[ ] $ 9,216.60
PARENT & CHILDREN:	[ ] $ 9,870.30
FAMILY:	[ ] $12,252.66

FLEXIBLE SPENDING ACCOUNTS (FSAs)

	Annual Target	Per Pay Amount
I. Medical Spending:	$ _____	/ 26 pays = $_____
Medical FSA Maximum: $2,650		
II. Dependent Care Spending:	$ _____	/ 26 pays = $_____
Dependent Care FSA Maximum: $5,000		

III. **ADD** the Total I + II = $ _____ ***divided by*** 26 Pays = …… **B. $_____/Per Pay**

-OVER-

Lakeland School District

TAX METHOD

Please indicate the Tax Method you wish to utilize for any applicable payroll deductions. All-State Insurance Premiums will be deducted after-payroll tax regardless of your election.

[ ] Pre-Payroll Tax, with Tax Savings [ ] After-Payroll Tax, without Savings

SIGNATURE

In signing this Form, I am stating that I understand and agree to the following:

1. I authorize the above selection and pre-tax contributions, if appropriate, for the next 12 months;
2. If I have not selected medical/dental coverage, I certify that I have adequate medical coverage for myself and my dependents elsewhere.
3. If for any reason I waive medical/dental or another benefit plan under this Program's coverages and as a result incur any expenses which are uncovered, I recognize that these expenses are my or my family's personal obligations.
4. I understand that if I have elected not to enroll in the medical plan(s), the current or future pre-existing conditions limitation may apply, notwithstanding the HIPAA rules, if I decide to join the plan(s) in the future.
5. I agree that if I have a change of family or employment status (Marriage, Divorce, Birth or Adoption, Death or Hours of Employment), I must notify LSD within 30 Days if I wish to change my elections with this Program.
6. I understand that certain benefit plans with this Program require insurance or plan applications and that if I do not complete the required forms, I will not be covered for those benefits or the benefit administrator will place my benefit under the administrator's plan rules.
7. I understand that any unused balance remaining in either Spending Account at the Plan Year end will be forfeited by me.
8. I understand that if a Spending Account claim is denied, I hold the right to have the claim reviewed by a panel of representatives comprised of LSD management and the plan administrator.
9. Any calculation error or omission of material facts of the form will be corrected by the Plan Administration; however, elections made on this form, despite any error or omission, will be deemed to be authorized by myself.
10. I understand that the all premium payments through payroll deduction for the Allstate Insurance programs will be an after-tax deduction.
11. I understand all of the provisions associated with the choice I have made, as described on this Form and in the Summary Plan Description (SPD), in electing between Health Insurance or the Cash Payment Policy. Under this agreement, I attest that I maintain replacement medical/health plan coverage through another source, as indicated on this Form for myself and my dependent(s). If I have elected the Benefits Waiver Policy Option, I understand that applicable health and medical insurance costs incurred by myself and/or my dependents will be filed against the medical plan I have cited on this Form as "Evidence of Other Medical Coverage", in substitution for the Medical Plan offered by LSD. I hereby agree to indemnify and hold my employer harmless from and against all claims, causes of action, suits, demands, costs, expenses, including attorney's fees and litigation-related costs liabilities and losses, however caused, which may result or arise from my election of the cash payment in lieu of medical plan coverage.

Signature _____ Date _____