ELECTION / DECLINATION FORM & SALARY REDUCTION AUTHORIZATION
FULL TIME AGREEMENT FOR OHIO VALLEY ESC

This form must be returned whether electing or declining by ____________________

Select Add, Drop or No Changes and mark the type of plan.
***If you are adding any type of insurance please complete and submit the appropriate enrollment form.**

Plan	Add	Drop	Waive	Change	No Changes
Plan A - Medical/Prescription Plan - Traditional					
Plan B - Medical/Prescription Plan - Qualified High Deductible					
Plan C - Medical/Prescription Plan - Qualified High Deductible with Health Saving Account (employer contribution)					
Dental Plan					
Vision Plan					
Board Paid Life Insurance	X				

Plan A - Medical/Prescription Plan - Traditional
- ☐ $148.62 Single Coverage
- ☐ $326.66 Employee + Spouse
- ☐ $250.86 Employee +Child/Children
- ☐ $458.78 Family Coverage

Plan B - Medical/Prescription Plan - Qualified High Deductible
- ☐ $ 91.00 Single Coverage
- ☐ $200.01 Employee+Spouse
- ☐ $153.60 Employee+Child/Children
- ☐ $280.91 Family Coverage

Plan C - Medical/Prescription Plan - Qualified High Deductible
with Health Saving Account (employer contribution)
- ☐ $109.06 Single Coverage ($1,500.00 H.S.A/yr)
- ☐ $239.90 Employee+Spouse ($3,000.00 H.S.A./yr)
- ☐ $184.24 Employee+Child/Children ($3,000.00 H.S.A./yr)
- ☐ $336.93 Family Coverage ($3,000.00 H.S.A./yr)

Dental Plan
- ☐ $ 4.51 Single Coverage
- ☐ $10.86 Family Coverage

Vision Plan
- ☐ $ 1.07 Single Coverage
- ☐ $ 3.11 Family Coverage

Board Paid Life Insurance

**If you are newly eligible or changing beneficiaries, please complete the Meta/Life Pay Beneficiary designation form.*

****Amounts are Pre-Tax Montly Amounts - deducted from your pay before taxes***

If you are declining/waiving enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you enroll within thirty-one (31) days after your other coverage ends. 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, provided that you enroll within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

A summary of the above plans has been furnished to me. I have read and understand the information in the summaries and I elect the benefits as indicated above. I understand that this Election Form and Salary Reduction Agreement revokes any prior election I have made under Ohio Valley ESC Cafeteria Plan and that this Election Form and Salary Reduction Agreement is irrevocable for the plan year (September 1 through August 31) and must be signed prior to the beginning of the plan year. If I fail to make another election for the next Plan Year, I will be treated as having made the same election for the next Plan Year. I understand and agree that Ohio Valley ESC can reduce my pay on a pre-tax basis as indicated above while this Election Form and Salary Reduction Agreement is in effect and that Ohio Valley ESC may reduce, cancel or otherwise modify this Election Form and Salary Reduction Agreement if it is believed necessary to satisfy certain sections of the Internal Revenue Code.

______________________________________ ______________________________
Signature Date Area Code Telephone Number

______________________________________ ______________________________
Printed Name Social Security Number