New Employee – Open Enrollment
Salary Reduction Agreement
Dependent Premium Conversion Plan

This form allows you to enroll and/or opt out of the Dependent Premium Conversion Plan, during Open Enrollment only.

Employee Information
(please print)

Name:	Social Security Number:
Address:	City, State, Zip:
Work Telephone Number:	Home Telephone Number:

( ) I elect to enroll in the Dependent Premium Conversion Plan. I authorize the State to redirect a part of my salary to pay premiums with pretax dollars for dependent premiums.

( ) I do not elect to enroll in the Dependent Premium Conversion Plan.

Terms and Conditions

I understand that:

I cannot change or revoke any of my elections on the salary reduction agreement at any time during the Plan Year (January 1 – December 31) unless I have a change in family status.

During open enrollment of each plan year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit elections then in effect for the new Plan Year.

If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

The Flexible Employees' Benefits Board may redirect or cancel my compensation redirection or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Service.

This Agreement is subject to the terms of the Flexible Benefits Plan, as amended.

Certification

I hereby certify that I have completely read and fully understand the terms and conditions of this form.

_____ _____

Employee Signature Date

STATE EMPLOYEES' INSURANCE BOARD
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