

LEDYARD BOARD OF EDUCATION – OPEN ENROLLMENT FORM
Teachers– Plan #225

EMPLOYEE:
EMP NO:
ADDRESS :

HIRED:
DOB:
PLAN YEAR: 7/1/16 to 6/30/17
LOCATION:

Here is your Open Enrollment form for 2016-17. Please check the boxes and/or fill in the amounts next to the benefit options you have selected. Once you have chosen your benefits, you can determine your total tax exempt deductions.

HEALTH & DENTAL INSURANCE			REIMBURSEMENT ACCOUNTS	
	2016-17 Rate (20 Pays)	2016-17 Election (Check One Box)		2016-17 Amount
LUMENOS with Dental/Vision			FSA - DEPENDENT CARE (\$5,000 max)	
Employee Only	\$84.02	<input type="checkbox"/>	Max: \$250.00 Single/Married Filing Jointly	<input type="checkbox"/>
Two People	\$169.60	<input type="checkbox"/>	\$125.00 Married Filing Separately	<input type="checkbox"/>
Family	\$231.55	<input type="checkbox"/>	FSA – Limited Purpose Medical Care (\$2,550 max) used w/HDHP	
Dental Insurance Only			Min.: \$10 Max. : \$127.50	<input type="checkbox"/>
Employee Only	\$4.26	<input type="checkbox"/>	EMPLOYEE PRE-TAX DEDUCTION SUMMARY	
Two People	\$10.02	<input type="checkbox"/>	Medical /Dental Plan Option	<input type="checkbox"/>
Family	\$12.24	<input type="checkbox"/>	Dental Only Plan Option	<input type="checkbox"/>
HSA			FSA - Dependent Care Option	<input type="checkbox"/>
HSA Deduction Amount (20 Pays) \$ <input type="text"/>			FSA – Limited Purpose Option	<input type="checkbox"/>
Employees may contribute an amount to their HSA through payroll deduction up to the IRS limit. Please review the maximum amounts below.			HSA Deduction	<input type="checkbox"/>
	Under 55	Over 55	Total Pre-Tax Deductions	<input type="checkbox"/>
Max Single	\$117.50	\$167.50	Post Tax Deductions:	
Max Dual/Family	\$237.50	\$287.50	Life Insurance (\$50,000)	<input type="checkbox"/>
Life Insurance \$50,000 (Not Pre Tax) Check Box			Disability Insurance	<input type="checkbox"/>
Employee only \$1.79 per paycheck <input type="checkbox"/>			Total Post-Tax Deductions	<input type="checkbox"/>
Long Term Disability (Not Pre Tax) Check Box				
Employee Only. Calculated on base salary: (Salaryx60%x.0068x.20/20) <input type="checkbox"/>				
HEALTH INSURANCE WAIVER				
I choose not to participate and/or elect health coverage through Ledyard Public Schools, as I currently have health insurance available through an alternate provider. Reimbursement is only open to those contractually eligible.			Single <input type="checkbox"/>	
			Dual <input type="checkbox"/>	
			Family <input type="checkbox"/>	
Insurance Company:				
<input type="text"/>				
Policy Number:				
<input type="text"/>				

I have read the summary plan description of the medical and flexible benefit plans and choose the benefits indicated on this form. I will stay with the benefit plans I have chosen until the next open enrollment or until I have a qualifying event which permits me to change my elections. I authorize my employer to adjust my paycheck to purchase the benefits indicated above.

Signature: _____ **Date:** _____