**Health Insurance**
**Regional School District 17**
**Mandatory Tax Status Election Form**
**18/19 Teachers**

Employees who are enrolled in the district's group health insurance have the ***option*** of electing the tax treatment of the premiums that are deducted from your salary.

*Pre-tax elections are applicable for the entire fiscal year, ***July 1, 2018 through June 30, 2019***. You cannot change or discontinue your elections during the plan year unless you have one of the following qualifying events:

- You get married or divorced
- You have a child or adopt one
- Your spouse or child dies
- Your spouse commences or terminates employment
- Your employment status changes from full-time to part-time or from part-time to full-time
- You or your spouse take an unpaid leave of absence
- Your spouse has a significant change in health coverage directly attributable to your
- spouse's employment
- Other qualifying events may also be considered

***Please note your election change must be consistent with the qualifying event.

| | Single | Two | Family |
|---|---|---|---|
| CT Partnership Plan MEDICAL Bi-wkly deduction 22 pays | $96.38 | $206.26 | $252.52 |
| DENTAL Bi-wkly deduction 22 pays | $ 5.33 | $ 10.67 | $ 17.34 |
| VISION Bi-wkly deduction 22 pays | $ .62 | $ 1.14 | $ 1.86 |

***Please check the appropriate box, sign this enrollment form and return it to Payroll by June 8th.***

**Pre-tax basis means the contribution is not taxed, it is taken prior to applicable state and federal withholding taxes**

______ **I elect Pre-Tax**. By checking this box, I understand that my salary will be reduced to pay for group health insurance premiums per my union contract or individual contract on a pre-tax basis.

**Post-tax means the contribution is taxed; it is taken after applicable state and federal withholding taxes.**

_____ **I elect Post-Tax**. By checking this box, I understand that my salary will be reduced to pay for group health insurance premiums per my union contract or individual contract on a post-tax basis. (Contributions towards health insurance will be after taxes)

______ **I am Refusing coverage in the District's Health Insurance (select one):**

____**I have coverage elsewhere** ____**I am not eligible for coverage** ____**I have No coverage**

**I understand my next opportunity to enroll for medical, dental and/or vision will be July 1, 2019 or if a qualifying event occurs. I understand that I am bound by the terms of this agreement until my employment terminates, a qualifying event occurs, my benefits change at the beginning of a new plan year, or my employer terminates, suspends, or modifies the plan.**

Employee's Signature________________________________________________Date______________

Employee Name (printed) ______________________________