Spelman College
2014 Health Plan Salary Reduction Agreement Form

Employee Information

Name: _____

Address: _____

_____

_____

Social Security or 900 Number _____

Please review the list of available plan options, and place a check ☑ ***in the space next to your selection.***

You are not required to enroll in all 3 plans.

Medical Plan

Open Access Plus-In Network		Open Access Plus	
☐ Employee only	$135.15 per month	☐ Employee only	$90.96 per month
☐ Employee + 1	$279.76 per month	☐ Employee + 1	$249.55 per month
☐ Employee + 2 or more	$329.76 per month	☐ Employee + 2 or more	$294.16 per month

Dental Plan

Dental HMO		Dental PPO	
☐ Employee only	$6.00 per month	☐ Employee only	$10.00 per month
☐ Employee + 1	$10.00 per month	☐ Employee + 1	$22.00 per month
☐ Employee + 2 or more	$17.00 per month	☐ Employee + 2 or more	$26.00 per month

Vision Plan

Vision PPO	
☐ Employee only	$2 per month
☐ Employee + 1	$3 per month
☐ Employee + 2 or more	$4 per month

Please add your individual monthly premium costs in the space below

Health Plan $_____/month Dental Plan $_____/month Vision Plan _____/month Total $_____

I elect to have my healthcare premiums payroll deducted on a
☐Pre-Tax Basis ☐Post-Tax Basis

I hereby certify that the information furnished in this form is true and complete to the best of my knowledge. I understand these benefits will remain in effect until I complete and file a new election form with the Office of Human Resources during an Annual Open Enrollment unless I experience a qualifying life event. If I experience a qualifying event, I understand that I have 30 days from the date of the event to make changes to my benefits. I understand Spelman College can change or end benefits at any time.

Employee Signature: _____ **Date:**_____