



## Bakersfield City School District Premium Only Plan (POP) Enrollment Form

<b>EMPLOYER:</b>	
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**Employee Information (Please print clearly)**

<b>NAME:</b>	First	MI	Last	MI	<b>SS#:</b>	<b>DATE OF BIRTH:</b>
<b>ADDRESS:</b>	Street Address or P.O. Box					<b>PHONE:</b>
	City		State		Zip	(      )

- Open enrollment
  New employee

Hours worked per week	Date of Hire:	Job Title:	Employment Status:
			<input type="checkbox"/> Full Time <span style="margin-left: 150px;"><input type="checkbox"/> Part Time</span>

**I elect the following Salary Reduction Agreement:**

- Election of **“Pre-Tax” Benefits Under the Salary Reduction Plan (premium amount is not subject to taxes)**

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for my group medical, dental, and/or vision coverage with “pre-tax” dollars. Such reductions, considered as elective contributions under the Plan, will start with my first paycheck dated after the effective date of enrollment. I further authorize future adjustments in the amount of the salary reduction in the event the cost of coverage should change. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that this election and the indication that a premium is to be paid does not provide insurance coverage. In most instances an application for insurance must also be completed.

- “Post-Tax” Election (premium amount is subject to taxes)**

I elect to waive all pre-tax benefits under the Plan, but I elect to pay for my Health Insurance Benefits on an after-tax basis. Except for an allowable Change of Status event, I understand that I cannot elect pre-tax benefits until the next Open Enrollment period.

I understand that my POP contributions (if any) for medical, dental and vision coverage will be made on a “Post-Tax” basis unless I have checked the “Pre-Tax” option above. This election shall remain in effect until a subsequent election form is filed in accordance with the Plan. An eligible employee who elects not to participate or does not return the enrollment form will automatically be made on a “Post-Tax” basis.

**I have read and agree to the terms of participation set forth in this Agreement.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_

*Return the completed form to your employer.*

**Employer’s use only**

Received and approved by authorized Qualified Employer: \_\_\_\_\_ Date: \_\_\_\_\_

Effective date of enrollment: \_\_\_\_\_ First payroll deduction date: \_\_\_\_\_