

# El Paso Independent School District

## Section 125 Premium Conversion Election Form

(Please print) ✍

\_\_\_\_\_  
School / Department

\_\_\_\_\_  
Dept. Phone # / Home Phone #

\_\_\_\_\_  
Employee Name (Last) (First) (Middle) Social Security #

\_\_\_\_\_  
Street Address/Mailing Address City State Zip Code

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Male	<input type="checkbox"/> New Employee
<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Family	<input type="checkbox"/> Female	<input type="checkbox"/> Change of Status
			<input type="checkbox"/> Annual Enrollment

\_\_\_\_\_ I hereby authorize and direct my employer to deduct from my salary the amount necessary to pay for the coverage shown below.

\_\_\_\_\_ Such deductions, considered as elective contributions under the Plan, shall commence with my paycheck dated:

\_\_\_\_\_ with an effective date of coverage \_\_\_\_\_.

*I understand that all Health Benefit premiums are paid a month IN ADVANCE of effective date of coverage.*

\_\_\_\_\_ Indicated below are benefits which I wish to elect for participation and the amount to be paid by Salary Reduction. **(TOTAL PER PAY PERIOD COST. AMOUNTS AS SHOWN ARE NOT PRO-RATED TO REFLECT ADDITIONAL PREMIUMS DEDUCTED FOR NINE AND TEN MONTH EMPLOYEES)** The selections will remain in effect until a subsequent election form is filed in accordance with the Plan.

BENEFIT * (All amounts are per pay period and have not been Pro-rated for 9 & 10 month employees or Proportionate employees)	PRE-TAX OPTIONS				POST-TAX OPTIONS			
	EMPLOYEE	SPOUSE	CHILDREN / FAMILY	SALARY DEDUCTION / REDUCTION TOTALS	EMPLOYEE	SPOUSE	CHILDREN / FAMILY	SALARY DEDUCTION / REDUCTION TOTALS
EPISD CLASSIC 500								
EPISD STANDARD 1000								
CDHP 3000								
EPISD HOSPITAL INDEMNITY								
EPISD DEPENDENT LIFE								
EPISD OPTIONAL LIFE								
VISION PLAN								
DENTAL								
DISABILITY								
TOTAL PAYMENT								

\_\_\_\_\_ \* I UNDERSTAND THAT THE SELECTION OF A BENEFIT AND THE INDICATION THAT A PREMIUM IS TO BE DEDUCTED DOES NOT NECESSARILY INCLUDE ME IN THE INSURANCE BENEFIT ELECTION(S) WHICH REQUIRE SUBMISSION AND ACCEPTANCE/APPROVAL OF AN APPLICATION AND/OR EVIDENCE OF INSURABILITY.

\_\_\_\_\_ **I FURTHER UNDERSTAND THAT IT IS MY RESPONSIBILITY TO VERIFY THAT ALL PAYROLL DEDUCTIONS AS STATED ABOVE ARE CORRECT AND TO IMMEDIATELY REPORT ANY DISCREPANCIES IN MY PAYROLL DEDUCTIONS ON MY PAYCHECK TO THE EMPLOYEE BENEFITS OFFICE TO GUARANTEE PROPER COVERAGE AND CONTRIBUTIONS.**

\_\_\_\_\_ I FURTHER UNDERSTAND THAT THIS ELECTION FORM WILL REMAIN IN EFFECT UNTIL I CHANGE IT. I UNDERSTAND THAT I MAY CHANGE MY PRE-TAX ELECTION(S) ONLY ONCE A YEAR DURING THE ANNUAL ENROLLMENT PERIOD. I CAN ALSO CHANGE MY PRE-TAX ELECTION(S) IF I HAVE A CHANGE IN FAMILY STATUS PROVIDED THAT I SUBMIT A CHANGE IN STATUS ELECTION FORM WITHIN 30 DAYS OF THE EVENT

\_\_\_\_\_ \*\* I understand that the insurance claim payments under certain disability coverages may be subject to Federal and State taxes when the premium is paid on a pre-tax basis.

\_\_\_\_\_ Insurance premiums will be deducted 24 times a year depending on your position with EPISD. This election and compensation reduction agreement will continue by its terms in the amount of the required contribution, for these benefit options. I further authorize additional reductions in the event that the cost of coverage in any program selected is increased during the Plan Year. Unless such increases are substantial, in the opinion of the Plan Administration, (the EPISD Employee Benefits Office), in which case I may cancel the election if permitted under the official plan document.

\_\_\_\_\_ 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 (Section 125).

\_\_\_\_\_ It is the responsibility of every participant to notify the EPISD's Employee Benefits Office within 30 days of any changes which will affect his/her eligibility or that of family members for benefits under this program (e.g. divorce, marriage, child turns of age, etc.). **Failure to notify the EPISD Employee Benefits Office of any such changes in family status may result in a suspension or termination of health coverage, waiver of COBRA Continuation Benefits, and any other legal rights and consequences the EPISD may pursue.**

\_\_\_\_\_ I understand that should I be on Worker's Compensation or Family Medical Leave (FMLA) status, I must make arrangement to continue to pay premiums and that failure to do so will result in termination of coverage. I also understand that any lapses in premium (deductions) for any component plan voids the entire Section 125 Agreement for the remainder of the plan year; except if I am returning from FMLA leave and resume participating in the Section 125 Premium Conversion Plan.

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AUTHORIZATION: I certify that I have read the foregoing and that the information stated is correct. I authorize the EPISD to make the deductions on a Pre-Tax basis or Post-Tax basis as indicated above.

I understand that I must be eligible and have completed any applications as necessary for a benefit as listed above before I may enroll in the Section 125 Premium Conversion Plan.

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

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