SISC
Self-Insured Schools of California
Schools Helping Schools

SISC FLEX PLAN
Premium Only Plan (POP) Enrollment Form

EMPLOYER:	

Employee Information (Please print clearly)

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

□ Open enrollment **□ New employee**

Employee's current Health Care Plan

□ Anthem Blue Cross □ California Care □ Other (Please Specify)
□ Blue Shield □ Kaiser

Hours worked per week	**Date of Hire:**	**Job Title:**	**Employment Status:**
			□ Full Time □ Part Time

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 "Pre-Tax" basis unless I have checked the "Post-Tax" option above. This election shall remain in effect until a subsequent election form is filed in accordance with the Plan.

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: _____

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