**Healthcare Contributions Only Plan:   
Salary Reduction Agreement**

**A Employee Information**

**- -**

**Name Social Security Number**

**Address**

**City State Postal Code**

( )

**Daytime Phone Email**

**B**  **Reason for Election** (check one):

❒ New employee enrollment ❒ Annual enrollment election ❒ Qualified life-change

Effective Date:

**C** **Salary Reduction for Employee Contributions**

I elect to participate in the Healthcare Contributions Only Plan and authorize my employer to withhold from my paycheck the required contribution towards my dues share for healthcare coverage.

**D** **Acknowledgment, Acceptance, and Signature**

I acknowledge that I have received the Healthcare Contributions Only Plan (the "Plan") document from my employer and I understand and accept the following terms and conditions:

* By completing and signing this form, I am authorizing my employer to withhold wages from my salary to pay my share of healthcare coverage I have elected.
* This authorization will continue in effect for as long as I am enrolled for healthcare coverage, unless I change my election during annual enrollment or I notify my employer and the Board of Pensions in writing of coverage changes due to a qualifying life event (as defined in the Plan document).
* I understand that these enrollment elections and my authorization to withhold my contributions cannot be changed except during annual enrollment or upon a qualifying life event.
* I am responsible for initiating any change in my elections due to a qualifying life event, as described under the Plan, within 60 days of such event.

**Employee’s Signature (*required*) Date**