Troup County School System
2023 Cafeteria Plan Election & Enrollment Form

Employee Name	☐ Female ☐ Male	☐ Married ☐ Single	Birthdate (Mo. Day, Yr.)	Hire Date (Mo. Day, Yr.)
Address	Emp. ID	Social Security Number		Effective Date
City State Zip	Location and Position			Annual Earnings
Pay Mode ☒ Monthly	Cell Phone	Email Address		Work Phone

☐ New Employee or Annual Enrollment	Change Due To: ☐ Marriage ☐ Death ☐ Adoption ☐ Name Change ☐ Qualifying Event ☐ Birth ☐ Divorce ☐ Terminated ☐ Other	Actively at work? ☒ yes ☐ no	☐ COBRA ☐ Retiree

▶ **Primary Beneficiary for Basic & Supplemental Group Life Insurance**	**Relationship(s)**
▶ **Contingent Beneficiary for Basic & Supplemental Group Life Insurance**	**Relationship(s)**

I ELECT TO RECEIVE THE FOLLOWING COVERAGES UNDER THE CAFETERIA PLAN ON A "PRE-TAX" BASIS:

I and my employer hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the plan year that remains after the date of this agreement). On this or the appropriate form(s), I have enrolled for the below benefits.

		Mo. Deduction
State Health Benefit Plan	**Must complete SHBP Membership Enrollment Form or Declination Form**	$
Medical Expense Reimbursement – Flexible Spending Account (Maximum $2,850/year or $237.50/mo.)		$
Dependent Care Reimbursement – Flexible Spending Account (Maximum $5,000/year or $416.67/mo.)		$
Basic Group Life Insurance - $25,000 paid by the Board of Education		No Cost
Supplemental Group Life Insurance $10,000 to $250,000 Guarantee Issue as New Hire	Amount: Employee Age: Rate:	$
Dental Insurance	☐ High Option ☐ Employee $49.13 ☐ Employee + One $87.30 ☐ Family $137.97 ☐ Low Option ☐ Employee $22.53 ☐ Employee + One $39.21 ☐ Family $ 80.93	$
Vision Insurance	☐ Employee $6.97 ☐ Employee +1 $12.54 ☐ Family $17.14	$

Covered Dependents

Dental	Vision	Last Name, First Name, Middle Initial	Relationship	Birthdate	SSN	Disabled?
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

I ELECT TO RECEIVE THE FOLLOWING ADDITIONAL COVERAGES ON AN "AFTER-TAX" BASIS:

Spouse Group Life Insurance $10,000 to $50,000 Guarantee Issue as New Hire	Amount: Employee Age: Rate:	$
Child Group Life Insurance	$10,000 = $1.30 $20,000 = $2.60	$
Long-term Disability Guarantee Issue as New Hire Only	Amount: 60% Earnings Employee Age: Rate:	$

I UNDERSTAND that if my required contributions for the selected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect the change. Prior to the first day of each plan year, I will have the opportunity to change my benefit elections for the following plan year. If I do not complete and submit a new election form prior to a new plan year, I will be treated as having elected to continue my benefit elections then in effect for the new plan year. In addition, I understand changes in the elected deduction and benefits can only be made in the event of a Section 125 qualifying event.

Any person who knowingly and with intent to defraud, submits an application containing materially false, or misleading information, commits a fraudulent act, which is a crime.

Date _____ **Signature** _____