

**SISC FLEX**  
**Premium Only Plan (POP) Enrollment Form**

|                  |  |
|------------------|--|
| <b>EMPLOYER:</b> |  |
|------------------|--|

**Employee Information (Please print clearly)**

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

- 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:  |
|-----------------------|---------------|------------|---|
|                       |               |            | <input type="checkbox"/> Full Time <input type="checkbox"/> 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.*

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**Employer’s use only**

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

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

Copy – White (SISC Flex)    Yellow – (School District)    Pink – (Employee)