



**SAN JOAQUIN DELTA COMMUNITY COLLEGE DISTRICT
PREMIUM ONLY PLAN (POP Plan)
Election Form**

Name: _____ Social Security Number: _____

1. Enrollment Type (Check One): Effective Date is October 1, 2009 or the first of the month following your date of hire or the date the enrollment form is signed, if later. You cannot be reimbursed for expenses incurred prior to the Effective Date.

- Annual Open Enrollment for plan October 1, 2009 through September 30, 2010
- New Hire Enrollment for new benefited employees through September 30, 2010
- Revised Enrollment due to Employment Status Change for promoted benefited employees through September 30, 2010
- Revised Enrollment due to Family Status Change for employees who have increases or decreases in dependent coverage through September 30, 2010

2. Election and Contribution:

Please select one:

- Premium Only Plan:** Money set aside in this account will be used to pay the cost of your health insurance premiums. I elect salary reduction in the amount necessary to satisfy the required contribution. I am expected to pay toward the cost of coverage for which I am eligible under the organization's group insurance plan. I understand that this is a pre-tax option and my Social Security Benefits may be reduced as a consequence of this election.
- I do not wish to elect salary reduction, please take the necessary contribution as a post tax salary deduction.

3. Authorization and Agreement:

The required contribution amount will be taken in equal installments on an annual basis from my paychecks while I am enrolled in this plan.

I understand that this authorization is irrevocable until the next election period unless I have a change in family status and the change I wish to make to my election is consistent with that change in status as specified in the Internal Revenue Code and regulations. All changes must be reported and a new election form must be completed within 30 days of the change.

Signature: _____ Date _____