

APPENDIX D

FREEDOM AREA SCHOOL DISTRICT
BENEFIT ELECTION FORM

You have the opportunity to participate in the Freedom Area School District Waiver of Health Care Coverage Plan (the "Plan") and elect to receive additional taxable compensation in lieu of health insurance coverage. Complete Section 1, sign at the bottom, and return this Election Form to the Business Manager. Your compensation will be increased in the amount as listed in Section 2. Only those employees who are eligible to participate in the Freedom Area School District Health Insurance Plan and are enrolled in another group medical plan, such as a spouse's plan, or covered by an individual policy, are eligible to participate in this Plan.

Irrevocable Election If you choose to participate in this Plan, you can not change or revoke your election until the next open enrollment period for the next Plan Year that runs from January 1 through December 31 unless you have a change in status as described in the Plan. Examples of a change in status are: marriage, divorce, death of your spouse or child, birth or adoption of a child, termination of employment of your spouse, switch from part-time to full-time employment or from full-time to part-time employment, beginning an unpaid leave of absence, or where there has been a significant change in your or your spouse's health coverage attributable to the spouse's employment. The election change must be requested within 30 days of the event, and must be on account of and consistent with the change in status as defined in the Plan.

1. Employee Information

Name: _____ SS#: _____

2. Election

For the Plan Year commencing January 1, _____, I hereby elect to receive the following benefit (select only one):

- ___ PPO Qualified High Deductible Health Plan
___ Waiver Compensation (\$2,000 per Plan Year) (\$1000 if half-time)

3. Waiver Compensation

By electing to receive Waiver Compensation, I am waiving participation in the Health Insurance Plan. I understand that I will receive additional taxable compensation during the Plan Year in the amount of \$2,000 such (or \$1000 for half-time employees) such payment being made with the May payroll. (Such additional compensation does not qualify as "compensation" as defined by the Pennsylvania State Employee Retirement Code and, therefore, is not subject to member-paid or employer-paid contributions to the Pennsylvania State Employee Retirement System).

4. Employee Statement and Signature

I hereby certify my election as designated above under the Freedom Area School District Waiver of Health Care Coverage Plan for the duration of the Plan Year. If I elected the Waiver Compensation benefit, I certify that I am covered for health care under another group/individual health plan as documented by my submission of such coverage. I acknowledge that I have read and understand any material (including the Summary Plan Description) concerning the effect of my election. I further understand that if I elected to waive receiving health insurance from the Freedom Area School District, I agree to hold Freedom Area School District harmless from any medical claim expenses incurred subject to group/individual health insurance plan coverage on my eligible dependents or myself. My election on this Election Form revokes any prior election relating to the same matter under the Plan. Before the beginning of each Plan Year, I will be offered the opportunity to change my election for the following Plan Year.

This Election Form is subject to the terms of the Plan as in effect from time to time and shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania to the extent not superseded by Federal law.

Employee's Signature

Date

Administrator Use Only:

[] Proof of other coverage received Date: _____ Received by: _____