Shawnee State UNIVERSITY

# *HEALTH PLAN PARTICIPATION AGREEMENT*
## *Full-time Benefit Eligible Employees*

Name: SSU ID:

Address: City: State: Zip:

*Remember to notify Human Resources if your marital status has changed in the past year.*

**PRE-TAX PREMIUM PAYMENT PROGRAM** *(for full-time employees eligible for SSU's health insurance plan)*

***I hereby authorize Shawnee State University to deduct from my salary, my premium contribution for coverage under the group health plan sponsored by Shawnee State University by the required method indicated below.***

**Employer Use Only**

Annualized amt $____________________

# of pay periods ____________________

Per pay deduction amt $_______________

☐ I elect to receive coverage under Shawnee State University's **Preferred Provider Organization (PPO)** plan and authorize reduction of my salary equal to my required contribution for this coverage under the group health plan according to the contribution schedule identified in the applicable collectively bargained agreement and Board of Trustees Resolution.

☐ I elect to receive coverage under Shawnee State University's **High Deductible Health Plan (HDHP)** plan and authorize reduction of my salary equal to my required contribution for this coverage under the group health plan according to the contribution schedule identified in the applicable collectively bargained agreement and Board of Trustees Resolution.

☐ I, the employee, am covered as the spouse or eligible dependent of a Shawnee State University policyholder.

☐ I decline (waive) coverage under Shawnee State University's group health plan and elect the cash payment option for ☐ single coverage, ☐ employee plus one coverage, or ☐ family coverage, subject to required withholding taxes. I certify that I am covered under the following group health plan:

Employer/Plan Sponsor ____________________________

Carrier/Plan Administrator ____________________________

Plan Account # ____________________________

Employee signature ________________________________________________ Date ____________________________

**Print, sign and return form with your election checked above to:**
***Human Resources/Benefits, Administration Building, Room 016***