Spectrum Enterprises

SALARY REDUCTION AGREEMENT

December 1, 2024 – November 30, 2025

Employee Name:		Social Security #
Address:		DOB
City, State, Zip		Gender
Telephone	Email	DOH

The Flexible Benefit Plan allows you to make your contribution toward your benefits with pre-tax dollars. These dollars are not subject to FICA, Federal or state income taxes. Once you have made your election, you may not change your election unless you experience a change in status. You may be able to change your benefit election when:

- You experience a change in your legal marital status;
- A child is born to you or you adopt a child; or your spouse or dependent dies;
- Your spouse either gets a job or loses a job;
- You or your spouse take or return from an unpaid leave of absence, a strike or lockout;
- Your health insurance cost or coverage changes significantly because of your spouse's employment (for example, your spouse's employer has open enrollment);
- A change in your or your spouse's work status (such as changing from part-time to full-time);
- You or your spouse's worksite changes which impacts your eligibility (such as moving out of an HMO service area);
- You, your spouse or dependent gain or lose eligibility;
- Your or your spouse's plan either adds or eliminates a benefit option;
- You, your spouse or dependent becomes entitled to Medicare or Medicaid.
- You become enrolled under the Exchange.

Note: To be permitted, any change in election must be consistent with the status event that has occurred.

BI-WEEKLY CONTRIBUTION	**CPOSII 6000 HSA**	**CPOSII 3500 HSA**	**CPOSII 5500 HSA**	**CPOSII 8150**
Employee	☐ **$28.23**	☐ **$91.69**	☐ **$35.30**	☐ **$0**
Employee + Spouse	☐ **$446.27**	☐ **$583.50**	☐ **$461.56**	☐ **$385.22**
Employee + Child(ren)	☐ **$370.25**	☐ **$494.06**	☐ **$384.04**	☐ **$315.18**
Family	☐ **$788.31**	☐ **$985.91**	☐ **$810.34**	☐ **$700.43**
Waive Medical Coverage	☐ **Waive Coverage**			

HSA Contribution: **Limits for 2025: $4,300 Individual & $8,550 Family**

DENTAL INSURANCE	**BI-WEEKLY CONTRIBUTION**	**VISION INSURANCE**	**BI-WEEKLY CONTRIBUTION**
Employee	☐ **$18.99**	**Employee**	☐ **$2.68**
Employee + 1	☐ **$34.77**	**Employee + 1**	☐ **$4.62**
Employee + 2 or More	☐ **$60.67**	**Employee + 2 or More**	☐ **$8.26**
Waive	☐	**Waive**	☐

DEPENDENT INFORMATION

	Name	SS#	DOB	Gender	Relationship
Dependent 1					
Dependent 2					
Dependent 3					
Dependent 4					

PLANS- CHECK ELECTIONS

Dependent 1- Medical ☐ Dental ☐ Vision ☐

Dependent 2- Medical ☐ Dental ☐ Vision ☐

Dependent 3- Medical ☐ Dental ☐ Vision ☐

Dependent 4- Medical ☐ Dental ☐ Vision ☐

Voluntary Life and AD&D Benefits

Please note: Election of Voluntary Life and AD&D Benefits requires an additional enrollment form. Please see HR.

DISABILITY BENEFITS:

Spectrum Enterprises pays 100% of the cost for this insurance.

Short Term and Long Term Disability Benefits are provided through Principal.

LIFE and AD&D BENEFITS

Spectrum Enterprises pays 100% of the cost for this insurance.

Basic Life and AD&D Benefits are provided through Principal.

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above. I understand this agreement will remain in effect until the end of the plan year unless one of the events listed in the **Summary Plan Description** occurs, in which case I may revoke or change this agreement as provided in the Summary Plan Description. I further understand that in the event the cost of a benefit I have selected for the plan year changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.
The plan(s) covered by this agreement is/are**: Medical, Dental, Vision Insurance**
I understand the above agreement.

_____ _____

Employee Name (please print and sign) **Date**