AUBURN UNIVERSITY
Salary Reduction Agreement
(For the Auburn University §125 Flexible Benefit Plan)
2021 Open Enrollment

Employee Name _____ **Banner ID #** _____

Participation in the Auburn University Benefit Plan: Please indicate your enrollment choices for the Benefit plans below. For plans you are participating in either write an effective date if you are making changes or write your initials if you are not making changes but will continue to participate. For plans you opt out of either write on effective date of the termination or write your initials if you are not making changes but will continue to opt out of the plan.

- Health Plan Effective Date:_____
- Dental Plan Effective Date:_____
- Vision Plan Effective Date:_____
- Flex Plan Effective Date:_____
- Cancer Plan Effective Date:_____
- Critical Illness Plan Effective Date:_____
- Voluntary Long Term Disability Plan Effective Date:_____
- Voluntary Long Term Disability Buy Up Plan Effective Date:_____

  - Opt out of Health Effective Date:_____
  - Opt out of Dental Effective Date:_____
  - Opt out of Vision Effective Date:_____
  - Opt out of Flex Effective Date:_____
  - Opt out of Cancer Effective Date:_____
  - Opt out of Critical Illness Effective Date:_____
  - Opt out of Voluntary Long Term Disability Effective Date:_____
  - Opt out of Voluntary Long Term Disability Buy Up Effective Date:_____

ACKNOWLEDGEMENT:

"My signature below acknowledges the following:

- I have chosen to enroll in the benefit plan(s} as indicated above as offered under the terms of the Auburn University Flexible Benefit Plan.
- I understand that, in addition to this Salary Reduction Agreement, I must also complete an online Enrollment Application for the benefit plan in which I choose to enroll in.
- For the benefit plan in which I am enrolled, I agree that my future salary will be reduced by the relevant cost of the benefit plan. If there is not enough salary to take the premiums, I will pay the premiums by cash or personal check in order to maintain coverage.
- This Salary Reduction Agreement shall be irrevocable and remain in effect until a participation option is changed or terminated.
- New enrollments/changes for currently covered employees and dependents can only be made in accordance with the federal regulations and the Health Insurance Portability and Accountability Act (HIPAA}.
- If I choose to opt out, I acknowledge that I have been informed of my rights to receive such benefits from a plan sponsored by Auburn University and that I am choosing not to elect the coverage made available to me above.
- I understand that the General Notice of COBRA Continuation Coverage Rights will be mailed to me at the address on file.
- I understand that if I do not return this form to Human Resources, Payroll and Employee Benefits in a timely manner, the start date of my benefit (s} coverage may be delayed."

_____ _____

Signature of employee ***Date***