

**MARLBORO COLLEGE**  
**Optional Insurance Salary Reduction Agreement (SRA)**  
**Plan Year: 2012**

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

I understand and agree that I may not change or revoke the salary reductions I indicate on this form during the plan year unless there is a family status change event, a change in cost, coverage or other-type change (judgment, decrees, etc.) permitted under the IRS code and regulations, and that justifies a change in my salary reduction agreement. Once I make the change indicated on this form, I may only reinstate or revise my salary reduction agreement as of the first day of the next plan year, unless there is another family status change event, change in cost, coverage or other-type allowable change (judgment, decrees, etc.).

I agree to notify the college if there is any change in my family status (i.e. birth, adoption, death, marriage, divorce, child ceases to be a student or child exceeds eligibility age of 26) that affects my insurance coverage.

Any election to participate in group dental or vision insurance coverage is subject to the rules and regulations as set forth by the Internal Revenue Service code and regulations, Northeast Delta Dental, VSP Vision Care, the Federal Department of Labor and the State of Vermont Department of Labor.

I authorize the following bi-weekly **pre-tax (Federal and State income tax and FICA) salary reductions** from my pay for the purpose of purchasing group dental or vision insurance coverage for myself and any dependents as listed on my enrollment form:

| <b><u>DENTAL - Current Election / New Enrollment</u></b> |                                      | <b><u>Effective</u></b> |
|--|--------------------------------------|-------------------------|
| <input type="checkbox"/> \$19.76                         | Northeast Delta Dental Single Plan   | ___/___/___             |
| <input type="checkbox"/> \$33.07                         | Northeast Delta Dental 2-Person Plan | ___/___/___             |
| <input type="checkbox"/> \$59.52                         | Northeast Delta Dental Family Plan   | ___/___/___             |

| <b><u>VISION - Current Election / New Enrollment</u></b> |   | <b><u>Effective</u></b> |
|--|---|-------------------------|
| <input type="checkbox"/> \$3.66                          | VSP Signature Plan Single Plan              | ___/___/___             |
| <input type="checkbox"/> \$5.86                          | VSP Signature Plan Employee + One Plan      | ___/___/___             |
| <input type="checkbox"/> \$5.99                          | VSP Signature Plan Employee + Children Plan | ___/___/___             |
| <input type="checkbox"/> \$9.65                          | VSP Signature Plan Family Plan              | ___/___/___             |

**For Taxable Domestic Partner Coverage:** I authorize the following bi-weekly **after-tax salary deduction** from my pay for the purpose of purchasing group health coverage for my taxable domestic partner's coverage as listed on my enrollment form (contact Anne Pratt for the exact amount):

\$ \_\_\_\_\_ Plan: \_\_\_\_\_ / \_\_\_/\_\_\_

**Reason for Change:** \_\_\_\_\_

I authorize Marlboro College to make the salary reductions indicated above and for the reason stated above, which to the best of my knowledge, is true, correct and complete. I understand that the status and participation changes must comply with the Plan and that the Plan Administrator has discretion in making this determination. I further understand that I may be required to provide documentation regarding the change(s) I have changed above.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date