Premium Payroll Deduction Agreement Form

You may choose to have your SAG-AFTRA Health Plan premiums deducted from your wages on a pre-tax basis over the course of a calendar year.

☐ **YES** — please deduct my Plan premiums from my paychecks on a pre-tax basis. By signing and returning this form, I authorize my employer, _____, to withhold the contribution I owe as an enrolled participant in the Plan. I understand these contributions will be withheld for ___ payroll periods during a calendar year.

I agree to reduce my compensation by $_____ (Step #2) pre-tax each pay period for the Plan year, subject to adjustments on a pro-rata basis in the case of a portion of the Plan year. This amount represents a deduction of $_____ (Step #1) per year ("annual election").

I authorize my employer, _____, to increase or decrease automatically this pre-tax compensation reduction if the cost of Plan benefits changes or my premium is increased or decreased due to a "qualifying life change" (i.e. marriage or divorce, birth or death of a dependent, child dependent becoming older than the Plan covers), which I have communicated to the Plan in a timely manner. My authorization for pre-tax deductions will roll over to future Plan years unless I notify the Plan and my employer in writing to cancel.

Step #1 — Calculate your premium rate (Plan I rates shown below)

Individual:	$300 quarterly $1,200 annually
Individual plus one:	$348 quarterly $1,392 annually
Individual plus two or more:	$375 quarterly $1,500 annually

Step #2 — Calculate your payroll deduction

$_____

Divide your premium rate from Step #1 by ___ pay periods (example: $1,680 divided by 24 = $70.00). Enter the amount above.

Note: Although there are _____ pay periods in a year, your annual premium will be deducted over _____ pay periods.

_____ _____

Participant name (print) Participant Social Security or HCID number

_____ ___/___/___

Participant signature Date

☐ **NO** — I do not want to pay my Plan premiums with pre-tax deductions from my paychecks, a choice that has been explained to me. Instead, I will receive quarterly premium invoices from the Plan in the mail, which I will be responsible for paying directly, or I will pay my premiums online in my Benefits Manager at www.sagaftraplans.org/health.

_____ _____

Participant name (print) Participant Social Security or HCID number

_____ ___/___/___

Participant signature Date