

KCTCS \$50 BENEFIT ALLOWANCE

(Please Check One)	New Hire <input type="checkbox"/>	Opt Over <input type="checkbox"/>	Open Enrollment <input type="checkbox"/>	Qualifying Event <input type="checkbox"/>
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Employee Name: _____ **Coverage Effective Date:** _____
Social Security No: _____ **Employee ID #:** _____
College District: _____ **Hire/Opt Date:** _____

The \$50 Benefit Allowance is a monthly employer paid benefit available to faculty/staff members covered under the **KCTCS Personnel System**. Eligibility is open to **KCTCS** faculty/staff members who have elected single Health Care Coverage or have waived their Health Care Coverage.

Individuals who have elected dependent Health Care Coverage or *who do not participate* in the **KCTCS Personnel System** *are not eligible* for this benefit.

You may use the \$50 monthly benefit by electing coverage:

- To pay for Health Insurance under the Kentucky Employees Health Plan (KEHP)
- To pay for Dental Insurance
- To put in a Health Care Flexible Spending Account
- To purchase Voluntary/Supplemental Benefits
- **You may NOT use this benefit towards your Group Life and AD&D Coverage or Supplemental LTD Coverage**

I have elected that my employer paid benefit be allocated as follows:

<u>Benefit:</u>	<u>Monthly Allocation</u>	<u>Paycheck Allocation</u>
Health Insurance	_____	_____
Dental Insurance Carrier: _____ Coverage Type employee <input type="checkbox"/> employee + one <input type="checkbox"/> Employee + Family <input type="checkbox"/>	_____	_____
Health Care Spending Account (FSA) (A new FSA Enrollment Form must be completed each plan year)	_____	_____
Supplemental Benefit (Life, Vision, Short Term Disability, Long Term Care, Cancer, Disease etc)		
Carrier: _____	_____	_____
Benefit: _____		
Carrier: _____	_____	_____
Benefit: _____		
TOTAL	_____	_____
	(\$50 Maximum)	(\$25 Maximum)

- I hereby authorize my employer to allocate this employer paid benefit as indicated above.
- I certify that I have waived or have elected single health insurance coverage and am a participant in the KCTCS Personnel System.
- I understand that my elections will remain in effect for the calendar year benefit plan year provided I remain an eligible KCTCS employee.
- Additional contribution allocated towards any employee benefits; including those listed above will be in accordance with IRS tax regulations.

Employee Signature _____ **Date:** _____
Human Resources Signature _____ **Date:** _____