SALARY REDUCTION AGREEMENT FOR THE CAFETERIA PLAN

Please complete the appropriate section below to indicate election or waiver of the Cafeteria Plan benefit. Return the completed form to the Department of Human Resource Management, Benefits Section—Room 124.

☐ I authorize LSU Health Sciences Center to reduce my salary by amount equal to the premium for insurance plans that qualify under the "Cafeteria Plan". The salary reduction agreement will become effective ___ ___ / ___ ___ / ___ ___.

I further understand that only during Annual Enrollment each year will I have the right to cancel the salary reduction agreement. If not canceled during Annual Enrollment, the agreement will remain in effect for the following year.

Changes in insurance coverage to reflect changes in family status (qualifying events) will be as follows: birth, adoption, marriage, divorce, death, and loss of eligibility of a dependent.

The Salary reduction agreement becomes null and void upon termination of employment, retirement or death.

______________________	______________________
Print Name	Signature
______________________	______________________
Social Security Number	Date

WAIVER OF CAFETERIA PLAN

☐ I waive my right to participate in the Louisiana State University Health Sciences Center "Cafeteria Plan" for the current plan year.

______________________	______________________
Print Name	Signature
______________________	______________________
Social Security Number	Signature