

“LIFE SCHOOL OF DALLAS, INC.”

SECTION 125 GROUP FLEXIBLE BENEFITS - EMPLOYEE ELECTION AND PAYROLL DEDUCTION FORM – 2009-10

NAME _____ Social Security # _____

I ELECT TO PARTICIPATE IN:	CHECK OPTION	ACTUAL MONTHLY DEDUCTION AMOUNT	ACTUAL BI-WEEKLY DEDUCTION AMOUNT (24 TOTAL DEDUCTIONS)
MAJOR MEDICAL PLAN (WLI BASE 80/60 PLAN):			
Employee	_____	\$ Employer Paid	\$ Employer Paid
Employee + Spouse	_____	\$ <u>782.13</u>	\$ <u>391.07</u>
Employee + Child(ren)	_____	\$ <u>386.99</u>	\$ <u>193.50</u>
Employee + Family	_____	\$ <u>1,173.19</u>	\$ <u>586.60</u>
MAJOR MEDICAL PLAN (NLE BUY-UP 100% PLAN):			
Employee	_____	\$ <u>75.57</u>	\$ <u>37.79</u>
Employee + Spouse	_____	\$ <u>1,002.78</u>	\$ <u>501.39</u>
Employee + Child(ren)	_____	\$ <u>543.35</u>	\$ <u>267.18</u>
Employee + Family	_____	\$ <u>1,466.38</u>	\$ <u>733.19</u>
VISION PLAN:			
Employee	_____	\$ <u>7.57</u>	\$ <u>3.79</u>
Employee + Spouse	_____	\$ <u>14.40</u>	\$ <u>7.20</u>
Employee + Child(ren)	_____	\$ <u>15.09</u>	\$ <u>7.55</u>
Employee + Family	_____	\$ <u>23.21</u>	\$ <u>11.61</u>
DENTAL PLAN :			
Employee	_____	\$ <u>14.31</u>	\$ <u>7.16</u>
Employee + Spouse	_____	\$ <u>44.51</u>	\$ <u>22.26</u>
Employee + Child(ren)	_____	\$ <u>53.96</u>	\$ <u>26.98</u>
Employee + Family	_____	\$ <u>94.05</u>	\$ <u>47.03</u>
AMERICAN PUBLIC SUPPLEMENTAL PLANS:			
Cancer	_____	\$ _____	\$ _____
ICU	_____	\$ _____	\$ _____
Hospital Indemnity	_____	\$ _____	\$ _____
TOTAL:		\$ _____	\$ _____

[] I have applied for certain eligible coverage under the Section 125 Salary Reduction Plan of “LIFE SCHOOL OF DALLAS, INC.”. This Salary Reduction Agreement, in accordance with the Plan Document, allows my employer to reduce my pre-tax wages by the cost of the benefits I have elected. I understand that this reduction may possibly reduce my FICA (Social Security) contributions and benefits. I understand that this agreement is irrevocable and cannot be changed or modified, except for the provisions that are provided for in the Plan Document, until the next open enrollment period. Any previous Salary Reduction Agreement under the plan relating to the same benefits offered herein is hereby revoked.

[] I decline the opportunity to enter a Salary Reduction Agreement at this time. I understand that my benefits deductions, if any, will be made after taxes have been withheld from my gross wages.

“LIFE SCHOOL OF DALLAS, INC.” and I agree that beginning the pay period after the effective date of coverage and continuing each pay period thereafter until this agreement is amended or terminated, my salary will be reduced by the amount of my required contribution for the benefits I have elected under this plan. The amount of my required contribution for each benefit selected is set forth on a schedule that has been provided to me. I understand that this agreement is irrevocable and cannot be changed or modified until the next Plan Anniversary (SEPTEMBER 1). Furthermore, any previous Salary Reduction Agreement under the Plan relating to the same benefits offered herein is hereby revoked.

Employee Signature _____ **Date** _____

(PLEASE SEE OTHER SIDE FOR POST-TAX DEDUCTIONS)

POST-TAX DEDUCTIONS

The following Benefits below are offered outside the Cafeteria Plan

MONTHLY
DEDUCTION

BI-WEEKLY
DEDUCTION
(24 TOTAL DEDUCTIONS)

Monthly Deduction
divided by 2

VOLUNTARY LIFE:

Employee \$ _____ \$ _____

Spouse \$ _____ \$ _____
(CANNOT EXCEED 50% OF EMPLOYEE LIFE AMOUNT)

Child(ren) \$ _____ \$ _____
(MUST HAVE EMPLOYEE COVERAGE FOR THIS OPTION)

Employee/Spouse rates / Spouse rates are based on Employee's age

Age	Monthly Rate per \$1,000 Benefit
<30	.06
30-34	.08
35-39	.10
40-44	.18
45-49	.26
50-54	.49
55-59	.88
60-64	1.40

Monthly Dependent Children Premium = \$2.00 for \$10,000

Coverage on all of your dependent children

Rates change on policy anniversary based on your attained age.

SHORT TERM DISABILITY: \$ _____ x _____ = \$ _____ \$ _____
Monthly Salary * Premium Factor

60% Basic Weekly Income to a maximum of \$500. Benefits begin the 8th day of Disability and continue up to 13 weeks.

Attained Age	Monthly Premium Factors
Less than 30	0.00789
30 - 34	0.00734
35 - 39	0.00692
40 - 44	0.00623
45 - 49	0.00637
50 - 54	0.00692
55 - 59	0.00831
60 - 64	0.00983

*Maximum covered payroll is \$3,611 Monthly

TOTAL POST TAX DEDUCTION

\$ _____ \$ _____
(Monthly) (Bi-Weekly)