

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.

Participant name (print)

Participant signature

Step #1 — Calculate your premium rate

Individual: \$390 quarterly
\$1,560 annually

Individual plus one: \$549 quarterly
\$2,196 annually

Individual plus, two or more: \$780 quarterly
\$3,120 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 Social Security or HCID number

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 signature

Participant Social Security or HCID number

Date