Attentive Enrollment and Salary Reduction Agreement

Asterisks (*) Denote Required Field

*Employer (School District)

*Last Name | *First Name | *MI | *Date of Birth

*Street Address | *City | *State | *Zip

*Social Security Number

*Home Phone | Work Phone | *Email Address

I Am Paid: ___Monthly

IMPORTANT: This Form Replaces and Cancels All Previous Salary Reduction Agreements On File

Deduction 1 ***(Start or modify an existing deduction)***

❑ Existing ❑ New ❑ Cancel	❑ **Attentive Preventative Care Plan**	
Start Date:	**End Date (If Applicable):**	Per Pay Period Amount: **$ 1173 Per month (with a reimbursement of $1173)** **Employee also understands they will pay a monthly fee of $89 from tax savings.**

By signing the Agreement, I authorize me employer to enroll me in the Attentive Preventative Care Plan. This enrollment will remain active until the next open-enrollment period or should I incur a qualifying event.

Employee Name (Print)

Employee Signature

Date of Employee Signature

403b Partners
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