MILITARY RESERVIST CALLED TO ACTIVE DUTY

NAME: _____ DATE: _____

DEPLOYMENT DATE: _____

SERVICE BRANCH: _____ RANK/GRADE: _____

BENEFIT PACKAGE:

Please indicate whether or not you would like to continue with your current coverage elections:

	Yes	No
Health insurance	_____	_____
Optional dental	_____	_____
Standard life insurance	_____	_____
Dependent life insurance	_____	_____
Flex medical reimbursement acct	_____	_____
Flex dependent care reimbursement acct	_____	_____
Certification Requirements/PTSB	_____	_____

If you elect to continue with your current coverage, you will be responsible to pay any premium amount over the District non-base contribution. Please complete the attached Authorization Agreement for Direct Payments and return with this form

Power of Attorney Information:
Name: _____
Address: _____
City, ST, Zip: _____
Phone Number: _____

To Any Armed Forces Employer:

I authorize you to release to the Goshen County School District No. 1 all the information contained in my earnings statement. I understand that Goshen County School District No. 1 will use this information to determine my eligibility for salary mitigation.

Signature _____ Date _____
SSN _____ Agency _____

Please attach a copy of your orders to this form. Also forward a copy of your first leave and earnings statement as soon as possible to begin compensation mitigation.

For District Use Only
Compensation Mitigation Computation:
Current placement on district salary schedule _____
Military base salary _____
Compensation change _____

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

GOSHEN COUNTY SCHOOL DISTRICT NO. 1
EMPLOYEES' GROUP INSURANCE PROGRAM

I _____, hereby authorize Goshen County School District No. 1 Employees' Group Insurance Program, hereinafter called EGI, to initiate debit entries to my y Checking y Savings account (select one), indicated below at the depository financial institution named below, called DEPOSITORY, and to debit the same to such account. The debit amount shall be equal to the premium amount due to EGI. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

DEPOSITORY
NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

ROUTING NUMBER _____ ACCT. NO. _____

This authorization is to remain in full force and effect until EGI has received written notification from me of its termination in such time and in such manner as to afford EGI and DEPOSITORY a reasonable opportunity to act on it.

NAME _____ SS# _____
(PLEASE PRINT)

SIGNATURE _____ DATE _____

PRIMARY INSURED _____ SS# _____

Note: all written debit authorizations MUST provide that the receiver may revoke the authorization only by notifying EIG in the manner specified in the authorization.

The letter you received with this authorization agreement describes the procedures associated with the Debit Authorization Program and is part of the Agreement

Adopted: March 9, 2004