NORTHWEST ALLEN COUNTY SCHOOLS
FLEXIBLE BENEFIT PLAN
ELECTION FORM/COMPENSATION REDUCTION AGREEMENT

Name:_____ **Email.:**_____

Address:_____ **Date of Birth:**_____

City, State, Zip:_____ **Plan year effective date: 10/1/2023**

My Employer and I agree that my compensation will be reduced by the amount of my required contribution for the benefit option(s) I have elected under the Plan (as noted below), effective on the first day of the Plan Year, and continuing until the last day of the Plan Year. I select the following benefit options and instruct the following amounts to be withheld from my compensation per pay period.

Premium Conversion Option

All qualified group insurance premiums, if any, will be deducted on a **pre-tax basis**.

General Purpose Health FSA Option (not available to HSA Participants) $ 3,050 limit

Check one in this section:

__ Annual Election Calculation: **$** _____ **X** ____18____ **=** **$** _____
Amount per pay period # of pay periods Total Election Amount

___I elect to not participate in the Medical Expense Reimbursement Option

Dependent Care (Child Care) Reimbursement Option $5,000 limit

Check one in this section:

___Annual Election Calculation: **$** _____ **X** ____18____ **=** **$** _____
Amount per pay period # of pay periods Total Election Amount

___I elect to not participate in the Dependent Care Reimbursement Option

I understand and agree that:

- I cannot change or revoke this election as of any date prior to the next Plan Year, unless I have an allowable status change as defined by the Plan Specifications.
- My required contribution, if any, for eligible employer offered insurance coverage will be deducted on a pre-tax basis unless I have notified my employer otherwise in writing. The rules of coverage and eligibility of any insurance coverage will be governed by the specific plans and not by the Flexible Benefit Plan.
- Prior to the start of the next Plan year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I don't complete and return a new election form at the time, I will be treated as having made an election of $0.00 for both the Medical Expense Reimbursement Option and the Dependent Care Reimbursement Option for the new Plan Year.
- As required by the Internal Revenue Service, any unclaimed amounts in my reimbursement account(s) at the end of the Plan Year will be forfeited by me after all submitted claims have been paid. Claims must be submitted within the time specified in the Plan Specifications.
- My employer may reduce or cancel this election, if necessary, to comply with the Internal Revenue Code.
- The reduction in my taxable compensation under this agreement will be in addition to any reductions under other agreements or benefit plans.
- I understand that any expense I submit for reimbursement must be for an eligible expenses incurred during the specific Plan Year. I understand the expense cannot be reimbursable under any other plan.
- I understand participation in the Dependent Care Reimbursement Option may reduce or eliminate my utilization of the child care tax credit contained in the Internal Revenue Code.

Employee's Signature: _____ Date: _____