FORM A

Rev. 10/15/2020

Cafeteria Plan – Election of Benefits Form

Option 1 - ELECTION OF HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

Health Flexible Spending contributions are limited to $2,750 per employee per calendar year Up to $550 of your year-end (12/31) balance will be added to your new Plan Year election Over-The-Counter (OTC) benefits are limited to Doctors' Prescriptions only, not needed during COVID

_____ I **elect** to participated in the FSA (**complete form D**) _____ I **do not elect** to participate in the FSA.

Option 2 - ELECTION OF DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCAP)

The maximum amount which may be allocated to the Dependent Care Flexible Spending Account is $5,000 per family per calendar year. (This limit may be reduced if you are married and you or your spouse are not employed full time or your spouse is a full-time student or your spouse is unable to care for him/herself.

_____ I **elect** to participated in the DCAP (**complete form D**) _____ I **do not elect** to participate in the DCAP.

Option 3 - ELECTION OF HEALTH SAVINGS ACCOUNT (HSA)

For employees on the Silver CDHP plan only. In addition to the District contribution to an HSA, if you elected it, you can elect to contribute to your account also. Limits are $3,600 for single and $7,200 for all other tiers, employee/employer contributions combined.

_____ I **elect** to participated in the HSA (**complete form G**) _____ I **do not elect** to participate in the HSA.

Option 4 - ELECTION TO RECEIVE EMPLOYER CONTRIBUTION AS CASH (HEALTH INSURANCE BUYOUT)

I am eligible for the Employer contribution because I am not electing health insurance benefits. I have completed the required forms and submitted a copy of my health insurance card; therefore, I will receive the employer's contribution to be paid to me on a date(s) chosen by my Employer ; this contribution will be taxed as regular income.

_____ I **elect** to participated in the buyout (**complete forms B&C**) _____ I **do not elect** to participate in the buyout.

Option 5 - WAIVER OF PREMIUM CONVERSION

All employee-paid health and dental insurance premiums will automatically be paid through the Lamoille North Supervisory Union Cafeteria Plan unless you elect not to participate. STOP: Consider your response, checking this box may not do what you think it will do. Most employees do not elect to participate in this part of the plan by NOT checking the box. Check this box ONLY is you DO NOT want your insurance premiums deducted on a pre-tax basis.

____I **do not elect** to participate in the Premium Payment part of this Plan. This means that all employee-paid premiums will be paid with after-tax dollars. I understand that I will not be receiving any payroll and income tax savings.

I have read and understand the "Other Terms and Conditions Statement" on page 2 before signing below.

_____ _____ _____

Printed name Signature Date

Other Terms and Conditions Statement

I understand that: I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the plan year unless I have a change in status. A change in status includes marriage, divorce, annulment, death of a spouse or dependent, birth, adoption or placement for adoption of a child, change of my employment status or that of my spouse or dependent, my or my spouse's or dependent's change in residence or worksite, change in dependent care cost due to a change in provider or fees (fees not applicable if the care provider is a relative), my spouse's or dependent's change in coverage under their employer's cafeteria plan or other qualified plan (change is not applicable to the Health Flexible Spending account), my or my spouse's or dependent's change in eligibility for Medicare or Medicaid, or such other events as the Plan Administrator determines will permit a change or revocation of an election. A change must be necessitated by and consistent with the change in status.

The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The redirection in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

The amount of my compensation redirection for each pay period during the year will be credited to reimbursement accounts or used to pay premiums on insured benefits and such amount will be paid on my behalf or I will be reimbursed, up to the balance in that account, for the applicable expenses incurred during the plan year.

Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits for me in a later plan year. **Up to $550 of the year-end account balance in your Health FSA will automatically be rolled to the new Plan Year and added to your new election.**

Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.

Premium Payments for employee-paid insurance premiums offered in this Plan will automatically be paid through this Plan unless I elect **not** to participate prior to the beginning of the Plan Year. Furthermore, I understand that my Employer will furnish me with an "Election Not to Participate" form upon my request.

Health Flexible Spending Account will be available for *"qualifying medical care expenses."* Generally, *"qualifying medical care expenses"* are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state and local income tax or social security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

If I cease my employment with the Employer, my participation in the Health Flexible Spending Account will continue if I so elect.
If I elect to continue participation, my salary redirections will continue with after-tax contributions for the remainder of the plan year.
If I elect not to continue participation, no further contributions will be made to the Plan on my behalf, although I may submit claims for expenses incurred during the plan year prior to my date of termination for up to 45 days from the date of termination.

I cannot seek reimbursement from this Plan for a medical expense which I intend on taking as a deduction on my tax return.

Dependent Care Flexible Spending Account will be available only for *"qualifying dependent care expenses,"* as described in the Internal Revenue Code Section 129, the plan document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state and local income tax or social security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

I agree to provide the Plan Administrator with the name, address and the taxpayer identification number of my dependent care service provider (if applicable).

I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this Dependent Care Flexible Spending plan.

My reimbursement account elections will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before reduction hereunder, is at least equal to the amount of that reduction.

I have received a copy of the Summary Plan Description for this Plan.

End of Plan Year claims for expenses incurred on or before December 31st must be submitted by February 15th or up to 45 days from the date of termination

This agreement is subject to the terms of the Lamoille North Supervisory Union Cafeteria Plan, as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation redirection agreement relating to such plan.

Lamoille North Supervisory Union Cafeteria Plan

FORM B
Rev. 10/25/2021

Sworn Statement of
Alternative Health Insurance Coverage

Health Insurance Buy-Out

Name:	Social Security #

The Lamoille North Supervisory Union Cafeteria Plan requires that you enroll in their group health insurance plan, unless you receive comparable alternative group health insurance coverage. If you have comparable alternative coverage, please complete the following, sign and return this form to the Plan Administrator. *Enrollment in an "individually purchased plan," such as coverage from Vermont Health Connect is not an eligible alternative health insurance plan nor is coverage through a Vermont school system.*

Alternative Coverage	
Plan Sponsor:	(Employer providing coverage)
Insurance Company:	
Effective for 12-Month Period Beginning:	**Please provide a copy of your health ins. ID Card***
My coverage is for (select one): ☐ Single; ☐ 2 Person; ☐ Family; or ☐ Medicare/TRICARE	

I certify that I am currently receiving comparable group health benefits as listed above. To the best of my knowledge this coverage is comparable to the health insurance provided by my Employer. I understand that the Plan Administrator reserves the right to refuse this statement based on a finding that the alternative coverage is not comparable.

**I understand that I will not receive the "Health Insurance Buy-Out" if I do not supply proof of insurance coverage (health insurance ID Card and or other information as requested) for myself and, if applicable, my spouse and or tax dependents.*

I understand that if my health insurance status changes during the Plan Year (Jan. 1 – Dec. 31), I must notify the Human Resources department at Lamoille North Supervisory Union.

Under penalty of perjury, I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct and complete.

Employee's Signature	Date
Authorized Delegate of the Plan Administrator	**Date**

Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547 FORM C Phone: (802) 828-2551

VT Form **HC-2**	**DECLARATION OF HEALTH CARE COVERAGE**	**This form must be completed annually by all uncovered employees. Employers must retain this form for 3 years.**

Employer: This form is **only** to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You must retain all employee declaration forms together in a file for three years and be able to produce them in the event of an audit.

Employer's Legal Name ***(Please print)*** _____

Employee: Complete and sign this form and return it to your employer. The purpose of this form is to obtain information regarding your health care coverage. The information you provide on this form will be used solely for purposes of determining if your employer must pay Health Care Contributions as required under Vermont law at 32 V.S.A § 10503.

Employee's Full Name ***(Please print)***	
Employee ID or Social Security Number	**Date of Birth**

Will the employee be under the age of 18 for the entire calendar year? ❑ YES ❑ NO

If **YES**, stop. Please sign the bottom of the form and submit it to your employer.

If **NO**, please continue to complete this form and submit it to your employer.

Check the box beside the statement that best describes your health care coverage.

1. My employer offers health care coverage to me.

❑ I have accepted the health care coverage offered and provided by my employer.

2. My employer offers health care coverage to me, and I have not accepted my employer's coverage.

❑ I have health care coverage that includes hospital and physicians services from a source other than Medicaid or Vermont Health Benefit Exchange.

My coverage is provided through: _____

❑ I am a full-time employee and have health care coverage as an individual through the Vermont Health Benefit Exchange.

❑ I have Medicaid.

❑ I have no health care coverage.

3. My employer does not offer health care coverage to me.

❑ I am a part-time employee who works fewer than 30 hours per week, **and** I have coverage from a source other than Medicaid that offers hospital and physicians services.

❑ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year, **and** I have coverage from a source other than Medicaid that offers hospital and physicians services.

❑ I have health care coverage that offers hospital and physicians services.

My coverage is provided through: _____

❑ I am a part-time or seasonal employee, and I do not have health care coverage **or** I am covered by Medicaid.

❑ I have no health care coverage.

❑ **I certify the above information is accurate and true to best of my knowledge and belief.**

Employee Signature _____ Date _____

Note: If your health care coverage changes within the year, you must complete a new Declaration of Health Care Coverage.