POST FALLS SCHOOL DISTRICT 273

Benefit Election Confirmation / Enrollment Form

Name:
Address:

Section 125 Flexible Benefit Enrollment

A Section 125 Plan allows employees to have eligible insurance premiums taken out of their paycheck before taxes. By electing to receive benefit coverage from Post Falls School District 273, I understand that the amount due for the coverage that I elect will be deducted on a pretax basis from each of my paychecks. Eligible benefits include medical/vision, dental, and group life insurance.

☐ **I choose to have the premiums for eligible insurance benefits contributed by pre-tax salary reduction.**

Terms and Conditions

I authorize payroll reductions for the listed insurance plans as my contribution to my Employer's Section 125 Cafeteria Plan. I understand that:

1. Changes in the cafeteria plan elections (other than with respect to Health Savings Accounts) can only be made at the end of the plan year unless due to and consistent with a valid status change (e.g., change in legal marital status; change in number of dependents; change in employment status; dependent satisfies or ceases to satisfy dependent eligibility requirements; residence change, cost or coverage changes) and such other events as would permit a revocation or change of election under IRC 125 regulations. Participation in this plan will automatically cease upon termination of employment. In most cases NO change may be made in the Medical Expense Reimbursement Account except for termination of employment. For special rules affecting your plan, please contact your employer. Unused funds remaining in the flex spending accounts at the end of the current plan year will be forfeited.

2. Execution of this benefit election/salary reduction agreement does not automatically institute insurance coverage; in most instances an application for insurance must be completed. Premiums charged for insurance coverage may be adjusted by the carrier issuing the contract and my "take-home" pay may be higher or lower depending on the selections made.

This authorization replaces any previous authorization I have made. **This Election Form shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form electing or changing any or all of the benefits listed on this form.**

OR~

☐ **I choose not to have my benefits taken by pre-tax salary reduction.**
(By choosing this option I understand that eligible insurance premiums will be deducted from my pay after tax.)

Employee Signature: _____ Date: _____