FORM A
Rev. 10/25/2022

Cafeteria Plan – Election of Benefits Form

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

Health Flexible Spending contributions are limited to $3,050 per employee per calendar year Up to $570 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 participate 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 participate 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 $3,850 for single and $7,750 for all other tiers, employee/employer contributions combined.

_____I **elect** to participate 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 participate 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 if 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 $570 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.

DataPath Administrative Services

HSA Application and Salary Reduction Agreement

FORM G
Rev. 10/11/2022

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account. **Do not send contributions with this form.** By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined in the adoption agreement and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Please fill out the form below and return to your payroll office.

Do you currently have an HSA with DataPath Administrative Services?

☐ **Yes** **Provide the name of the prior employer you had an HSA with and complete all sections.** Prior Employer Name _____

☐ **No** **Complete ALL information and sign the form.**

Section 1: Account Holder Information (Please Print)

Name (First, MI, Last) _____

Preferred Mailing Address ☐ Home Address ☐ Mailing Address (if different)

Home Address _____ Mailing Address _____

City _____ City _____

State _____ Zip _____ State _____ Zip _____

Email Address _____

Preferred Phone Number ☐ Home ☐ Work Best Time to Call _____ ☐ AM ☐ PM

Home Phone(____) _____ Work Phone (____) _____

Date of Birth _____ Social Security Number _____

Driver's License Number _____ Mother's Maiden Name (Security) _____

Employer School/Agency _____

Section 2: Primary Beneficiary

Name (First, MI, Last) _____ Percentage _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Relationship _____

If all individuals listed as Primary Beneficiaries precede you in death or cannot be located after a reasonable search by the custodian, all non-allocated funds (if any) in your account will be distributed to your Contingent Beneficiary (to add/edit/change Contingent Beneficiary(ies), log in to your account). In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

Section 3: HSA Contribution Election

HDHP Effective Coverage Date 01/01/23 Check one: ☐ Single Coverage ☐ Family Coverage

I elect a payroll contribution of $_____ (amount) to my HSA effective 01/13/23 **(date).**

Section 4: Debit Card

☐ **I hereby request a debit card as an alternate distribution method from my HSA account.** (See Article IV of the Custodial Account Agreement for terms of usage.)
Print exactly as you would like it to appear on your card: *21 characters maximum including spaces.* If more than two cards are needed, attach a separate sheet.

Name on 1st Card ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name on 2nd Card ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section 5: Adoption Agreement/Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that DataPath Administrative Services, Inc. is facilitating but not initiating the contribution. If the account is closed at any time, there will be a $25 closing fee.

This application is for the establishment of my individually owned Health Savings Account at the custodian displayed below. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement, and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the bottom of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I am currently, or will be upon the date of my first contribution, an Eligible Individual as described in the Custodial Account Agreement. I understand that maintaining my eligibility is my responsibility and that the cusodian will assume that all contributions are made while I am eligible to do so. I am currently, or will be upon the date of my contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

Signature of Account Holder _____ ***Date*** _____

Employer Signature: The employee's election of the Health Savings Account contribution is accepted as of the date below.

Employer Signature _____ ***Date*** _____

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