IMPERIAL COUNTY OFFICE OF EDUCATION
SECTION 125 FLEXIBLE BENEFITS PLAN

COMPENSATION REDUCTION AGREEMENT
Plan Year: January 1, 2009 through December 31, 2009

PLEASE TYPE OR PRINT CLEARLY

Section A: EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial	Social Security #
Mailing Address	City/State	Zip Code	

Home Phone Number	Work Phone Number	FAX Number	Email Address

Is this a new address? Yes ☐ No ☐

- Is your employment scheduled to terminate prior to December 31, 2008? Yes ☐ No ☐
- If YES, what is the termination date? ________________ Reason for termination: ____

Section B: DEPENDENT CARE SPENDING ACCOUNT

I elect to enroll in the *Dependent Care Spending Account* and authorize the following to be deducted from my paycheck on a pre-tax basis for the Plan Year:

$___________ Annual Amount (Annual Maximum $5,000 - to be deducted equally over: ___ 10 mo. ___ 11 mo. ___ 12 mo.)

If you enroll in the Dependent Care Spending Account only, the administration fee, if any, will be added to the amount you elect up to a total of $5,000. If enrolling after January 1st designate the amount to be deducted for remainder of the Plan Year (thru December 31).

Section C: MEDICAL SPENDING ACCOUNT

I elect to enroll in the *Medical Care Spending Account* and authorize the following to be deducted from my paycheck on a pre-tax basis for the Plan Year:

$___________ Annual Amount (Annual Maximum $3,000 - to be deducted equally over: ___ 10 mo. ___ 11 mo. ___ 12 mo.)

If you enroll in the Dependent Care Spending Account only, the administration fee, if any, will be added to the amount you elect up to a total of $3,000. If enrolling after January 1st, designate the amount to be deducted for remainder of plan year (thru December 31).

Section D: INSURANCE PREMIUM PAYMENT BENEFIT

☒ **To be deducted equally over each pay period for the Plan Year stated above..**

I understand and authorize that I am enrolled in the *Insurance Premium Payment Benefit.* I further authorize 100% of the employee's share of the costs to cover myself and my dependents, if applicable, in my Employer's health and welfare benefits plans that I have selected, to be deducted from my paycheck on a pre-tax basis for the Plan Year, which includes the administration fee, if any. I am aware that the premium amount that will be deducted from my paycheck may be changed at the sole discretion of the Employer and/or the Administrator during the Plan Year due to a change in my dependent status and/or the costs of the benefits I have selected.

- I hereby authorize my Employer to reduce my gross salary (before federal, state, and Social Security taxes are calculated) by the total amount indicated above.
- I understand that to participate I must complete a new Compensation Reduction Agreement each Plan Year.
- I understand that participation is not automatic.
- I understand the contribution to my Social Security account may be reduced, which may affect my Social Security benefits at retirement and disability.
- I understand that any amount remaining in the spending accounts that are not used during the plan year will be **forfeited** since IRS regulations state that the money cannot be carried forward to the next Plan Year or returned to me.
- I understand that the funds in the spending accounts can only be paid out to reimburse payment of allowable expenses actually incurred during the Plan Year while I am actively participating in the 125 Plan.
- I understand that my election is **irrevocable** for the Plan Year, unless I have an allowable status change.
- I understand that any status change must be reported to Envoy Plan Services, Inc., the Third-Party Administrator ("Administrator"), within 90 days of the status change. Otherwise, my election cannot be changed. (See Plan Highlights on the back of this form.)
- I have reviewed and understand the information on the back of this form.
- I have been given the opportunity to talk to a 125 Plan Administrator representative.
- I understand that upon execution of the proper form, reimbursement will be directly deposited into my bank account.

If I do not want direct deposits I must check this box. ☐

Section E: EMPLOYEE SIGNATURE:	Date:

Revised – 11-7-08

INSTRUCTIONS FOR COMPLETING THE COMPENSATION REDUCTION AGREEMENT

Section A:	**Employee Information** – Complete all of Section A.
Section B:	**Dependent Care Spending Account** – Complete only if you wish to enroll in the Dependent Care Spending Account for reimbursement of allowable child care expenses.
Section C:	**Medical Spending Account** – Complete only if you wish to enroll in the Medical Spending Account for reimbursement of allowable health and dental care expenses.
Section D:	**Insurance Premium Payment Benefit –** Enrollment is automatic in this benefit unless the Employer and/or the Administrator are notified otherwise in writing by the employee.
Section E:	**Employee Signature** – Sign and date this section (required).

PLAN HIGHLIGHTS (Please see the Plan Document for a complete explanation of the 125 Plan provisions)

I understand that with the **Dependent Care Spending Account**:

- Dependent care expenses are reimbursable if my spouse (if I am married) and I are both employed or if my spouse is a full-time student.
- I may not claim services for periods I did not work or while not on duty (or my spouse if I am married), (e.g., leaves of absence, vacation, sick leave, etc.)
- Dependent care expenses must be for my dependent children under age 13 or other dependents (e.g., a physically or mentally handicapped relative or other person living in my home that is unable to care for himself/herself and over half of whose support I pay).
- I can contribute up to $5,000 per year if I am a single parent, or married and filing a joint return. The maximum is the total family contribution allowable and must include the annual administration fee, if any. My maximum may be less if:
  - I or my spouse earns less than $5,000; or
  - I or my spouse is a full-time student or incapable of self-care; or
  - I am married, but file a separate federal tax return.

  If any of the above exceptions apply, please call the Administrator, Envoy Plan Services, Inc. at 1-800-248-8858.

- My spouse or anyone I claim as a tax dependent cannot provide care.
- I cannot claim as a tax credit the same dependent care expenses that are reimbursed under this Plan.
- Claims will be reimbursed for the amount of my eligible "out-of-pocket" expenses up to the amount in my account.
- I will be required to identify the person or agency performing the child care services to the IRS by providing the federal tax I.D. number or social security number.

I understand that with the **Medical Spending Account**:

- Health-related expenses are reimbursable if they are considered "deductible" medical expenses on my tax return as defined under Section 213(d) of the Internal Revenue Code ("IRC"). Insurance premiums, over-the-counter drugs, and unnecessary cosmetic surgery are examples of ineligible expenses. See IRS Publication 502 for guidelines. I cannot claim on my tax return the same health care expenses that are reimbursed under this Plan.
- The maximum amount I may contribute is $3,000 per Plan Year, plus the annual administration fee, if any. If both my spouse and I are eligible for the 125 Plan Medical Spending Account, we may each contribute up to $3,000 per plan year.
- My claims will be reimbursed for the amount of my eligible "out-of-pocket" expenses up to my annual election, minus previous claims paid.
- I may be eligible to continue in the Medical Spending Account on an after-tax basis through COBRA if a qualifying event occurs, such as separation from service.

I understand that with the **Dependent Care and Medical Spending Accounts**:

- My election is irrevocable for the Plan Year, unless I have an allowable status change. Examples of allowable status changes include, but are not limited to: changes in legal marital status, changes in the number of dependents, or changes in employment status.
- I must submit a written status change form to the Administrator within 90 days of the status change event. Otherwise, my election cannot be changed. The election change must be consistent with the status change and may be made on a **prospective** basis only after the Administrator's receipt and approval of the required status change forms.
- I will have 90 days following the end of the Plan Year to file claims for expenses incurred during the Plan Year.
- Claims must accumulate to a total of $15 before reimbursement will be made, except that at the end of the Plan Year, amounts less than $15 will be reimbursed.
- All forms and receipts must contain complete information before my reimbursement can be processed, and must be received by the Administrator no later than 90 days following the end of the Plan Year. Corrected claim forms received after this date cannot be reimbursed.
- If I am required to pay a monthly administrative fee to participate, the fee will be deducted from my paycheck on a BEFORE-TAX basis; if I participate in one or both flexible spending accounts there will be one monthly fee. Contact the Administrator for the current administration fee.
- Any money left in my account(s) after the 90th day following the end of the Plan Year, (after I have claimed all eligible expenses for that year) will not be reimbursed to me and will be **forfeited** to my employer pursuant to the IRC Section 125. The IRS considers the date of a claim as the date the service is rendered, not when the bill is actually paid.

I understand that with the **Insurance Premium Payment Benefit:**

- My election is irrevocable for the Plan Year, unless I have an allowable status change. Examples of allowable status changes include, but are not limited to: changes in legal marital status, changes in the number of dependents, or changes in employment status.
- I must submit a written status change form to the Administrator within 90 days of the status change event, otherwise, my election cannot be changed. The election change must be consistent with the status change and may be made on a **prospective** basis only after the Administrator's receipt and approval of the required status change forms.
- The dollar amount of the deductions from my paycheck may change during the Plan Year, only if the premium costs for the health and welfare benefits that I have selected change during the Plan Year which are identified as being insignificant. In the event of a significant increase in costs I may revoke my election. The Administrator in its sole discretion will determine if the increased costs qualify as insignificant or significant.
- Health and welfare benefits for me, and my dependents if applicable, that are covered under this election may include, based upon my selection: Medical Insurance, Dental Insurance, Vision Insurance, and Mental Health Insurance.