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Wappingers Central School District
FLEXIBLE BENEFITS PLAN
Election Form and Compensation Reduction Agreement

☐ **Check here for any name or address changes**

Employee Last Name: _____ First Name: _____ MI: ___

Employee Social Security Number: _____DOB: _____Sex:___ Marital Status:_____

Employee Address: _____

City: _____State: _____Zip: _____

Email Address: _____Phone Number (___)_____

Date of Hire: _____ Enrollment Date: _____

Flexible Spending Plan Year: July 1, 2020 through June 30, 2021

My employer and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

I. Premiums Under Certain Benefit Plans

I may be eligible for certain health, dental, and/or vision insurance coverages.
Where I have enrolled for such plan(s), my premium contributions will be paid, if any, on a pre-tax basis, unless I complete an "Election Not to Participate" form available through my employer.

II. Unreimbursed Medical Expense Account

I elect to make contributions to a medical reimbursement account for this plan year as follows:
Amount of compensation reduction: $ _____ **per pay period**, for **20** pay periods.
Yearly compensation reduction: $_____
The annual plan limit is $2,500 per participant.

Qualifying Medical Care Expenses

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your federal income tax return with certain exceptions (i.e., health insurance provided by a spouse's employer cannot be reimbursed).

III. Dependent Care Assistance Account

I elect to make contributions to a dependent care assistance account for this plan year as follows:
Amount of compensation reduction: $ _____ **per pay period**, for **20** pay periods.
Yearly compensation reduction: $_____
(Up to $5,000 or $2,500 if married filing separate tax returns)

List all eligible dependents:

Name	SSN	Relationship	Sex	Date of Birth ***REQUIRED***

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S FLEXIBLE BENEFITS PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME; AND SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS. I UNDERSTAND THAT I CANNOT CHANGE ANY OF MY ELECTIONS DURING THE PLAN YEAR UNLESS I HAVE A CHANGE IN FAMILY STATUS AND THAT ANY MONEY LEFT IN MY ACCOUNT(S) AT THE END OF THE PLAN YEAR WILL BE FORFEITED.

Employee's Signature _____ Date _____

Accepted and agreed to by the employer's Authorized Representative.

By _____ Date _____

Please mail completed form to: Business/Human Resources Department