Albany-Schoharie-Schenectady-Saratoga BOCES

Section 125 Benefit Plan
Enrollment Application

Plan Year: January 1, 2010 - December 31, 2010
Plus Plan Year Extension to March 15, 2011

Please print clearly

Name:_____ Building or Department:_____
Last First MI

Street Address or PO Box #:_____ SS Number:_____

City:_____ State:_____ Zip:_____

Telephone: (Home)_____ (Work with Extension)_____

E-Mail Address (Required): _____

Employment Year (Months): ☐ 10 mo. ☐ 12 Mo. _____ Specify

Pay Schedule: __X__ Bi-Weekly

In accordance with the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected. The BOCES and I agree that my compensation will be reduced by the amounts set forth below for each pay period designated by BOCES and plan year (or during such portion of the year as remains after the date of this agreement).

Medical Insurance Premium Plan:

☐ I elect to enroll in the Albany-Schoharie-Schenectady-Saratoga BOCES's Medical, RX, Dental, and Vision Care Insurance Premium Plan and to have my portion of premiums paid on a pre-tax basis, for this and subsequent years.

☐ I elect to enroll in the Albany-Schoharie-Schenectady-Saratoga BOCES's Medical, RX, Dental, and Vision Care Insurance Premium Plan and to have my portion of premiums paid on a post-tax basis, for this and subsequent years.

I understand that if my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease.

FLEXible Spending Plan:

Election of Medical Reimbursements

I elect the following amounts to be withheld from my paycheck this plan year. I understand that I will NOT pay Federal, State Income, or FICA taxes on the amount withheld.

$_____ this plan year for the **Unreimbursed Medical FLEX Account**
(minimum $200; maximum $3,000)
Note: No premiums (eg. COBRA) may be paid through this account.

For Office Use Only
# of Pay Periods **Per Pay Period**
_____ = $_____

I understand that:

♢ Reimbursements will be available only 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 BOCES 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 BOCES on demand for any liability it may incur for failure to withhold Federal, State or Local Income tax or Social Security tax from any reimbursement I receive of a non-qualifying expenses, up to the amount of additional tax actually owed by me.

♢ This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year.

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

(Over)

Election of Dependent Care Assistance

For Office Use Only	
# of Pay Periods	**Per Pay Period**
_____	= $_____

$_____ this plan year for the **Dependent Care FLEX Account**
(Up to $5,000 or $2,500 if married and filing separate)
Note: No kindergarten tuition may be paid through this account.

☐ I elect **NOT** to participate in the Flexible Spending Accounts for this plan year.

I understand that:

◊ Reimbursement 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 BOCES 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 BOCES on demand for any liability it may incur for failure to withhold Federal, State or 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 Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred.

◊ I agree to provide the Administrator with the name, address, and if applicable, the taxpayer identification number of the service provider.

◊ This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year.

◊ I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

OTHER TERMS AND CONDITIONS

I understand that:

◊ I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage.

◊ The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event that it is believed advisable in order to satisfy certain provisions of the Internal Revenue Code.

◊ The reduction in my compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by BOCES.

◊ My Social Security benefits may be slightly reduced as a result of my 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. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my Health Care/Dental Coverage elections then in effect for the new plan year but **not** for my medical reimbursements and/or dependent care salary redirection.

Salary Redirection Agreement

I have read and understand the explanation I have received regarding my options under the Albany-Schoharie-Schenectady-Saratoga BOCES FLEXible Benefit Program. I hereby apply for the options listed above and I authorize the BOCES to redirect my salary during the plan year as indicated. I understand that I cannot change any of my elections during the plan year (unless I have a change in status), and that any money left in my account(s) at the end of the plan year will be forfeited.

Employee Signature **Date** **Employer Signature** **Date**

Please Return to the *Payroll Office before December 7, 2009*

10/09