BASIC pacific **FLEXIBLE BENEFIT PLAN**

Enrollment form & Salary Reduction Agreement

EMPLOYER: Sacramento City Unified School District PLAN YEAR: January 1, 2019

1 Employee Information

FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	DAYTIME PHONE NUMBER	E-MAIL ADDRESS	SEX
			☐ Male ☐ Female

2 Making Your Elections - ***Enter your election for each account.***

Medical Expense FSA

☐ **Yes, I elect to participate in the Medical Expense FSA. The amount I elect for the PLAN YEAR is entered below (maximum election $2,700):**

$_____ *

* Your election will be deducted from your pay in equal installments each pay period throughout the Plan Year.

Dependent Care FSA

☐ **Yes, I elect to participate in the Dependent Care FSA. The amount I elect for the PLAN YEAR is entered below (maximum election $5,000):**

$_____ *

* Your election will be deducted from your pay in equal installments each pay period throughout the Plan Year.

Pre-Tax Premium Plan ("POP")

If you contribute toward the cost of your group health insurance, you are automatically enrolled in the pre-tax premium plan (POP). You do not need to sign any forms to save taxes on your health insurance contributions.

3 Salary Reduction Agreement

I authorize my employer to reduce my taxable compensation as directed above each pay period during the year. I fully understand that:

- I understand that I must be "common law employee" (as defined by my employer) to participate in the Plan. I further understand that if I am "self-employed" (as defined under Code § 401©, which includes a sole proprietor, partner in a partnership, over 2% owner of a S-Corp {or the employee spouse or dependent of a more than 2% owner of an S-Corp}, I may not participate in the Plan.
- Once made, my elections are "irrevocable" during the plan year unless I experience a "qualifying and related change in status" or other permissible event as defined in the Plan and by the Internal Revenue code(IRS). I further understand that my employer may modify or revoke my elections in any way it deems necessary in order to maintain the flexible benefit plan in compliance with all applicable provisions of the IRS. I further understand that my elections are in addition to any other agreements I have with my employer.
- If my contributions for health insurance change by an insignificant amount during the plan year, my employer will automatically adjust my pre-tax contributions accordingly.
- I will forfeit contributions that I have not claimed from my FSA accounts after the end of each plan year (the run-out period). The length of the run-out period is stated in my Summary Plan Description.
- I may be offered COBRA for my Medical Expense FSA if I otherwise qualify.
- Tax-free reimbursements from my FSA's may only be made for qualified expenses incurred (date services are rendered) during the plan year and may not be carried over into future plan years. I understand that reimbursements are based on the amount I owe for qualified expenses and NOT on the amount I pay or have paid.
- Services must be rendered (performed) before I may be reimbursed.
- By participating in my flexible benefit (cafeteria) plan, I could potentially reduce my social security benefits.
- This agreement is subject to all the terms and conditions of our flexible benefit plan, as amended and revokes any prior election and redirection agreement I may have completed.
- Prior to the start of each plan year, I will have the opportunity to change my premium (POP) election for the following plan year. If I do not change my POP election, my current election will automatically renew for the new plan year. However, I understand that I must make a new election for the reimbursement accounts prior to each future plan year in order to continue my participation from year to year.
- If applicable, electing to pay the premium for disability insurance with pre-tax dollars will result in my having to pay taxes (including wage taxes during the first six months of benefit payments) on any benefits received under the disability insurance policy.
- Prior to the start of each plan year, I will have the opportunity to change my elections for the following plan year.
- I am responsible to compare (or obtain assistance from a qualified tax advisor) the benefits provided by applicable tax credits and have determined that my election is in my best interest.
- I am responsible to reimburse my employer for benefits paid, taxes, penalties or interest that may be imposed as a result of my knowingly violating the terms of the Plan.
- If I participate in one or more of the reimbursement accounts, I understand that (1) My employer will deduct a fee from my pay each pay period to offset the administrative expenses of the Plan; (2) I will not be charged an additional fee if I participate in more than one account; and (3) I pay nothing to participate in the premium (POP) account.

I authorize the above elections and subsequent adjustments to my base annual salary. I understand and agree to abide by the rules and restrictions of the plan. I certify that the above information is true and accurate. I understand that any unused amount of the above designated plan are forfeited (use it or lose it)

EMPLOYEE SIGNATURE:_____ **DATE:** ____/____/____

To be completed by Employer

AUTHORIZED SCUSD SIGNATURE	BENEFITS EFFECTIVE DATE (May not precede date employee signed form)	BARGAINING UNIT	HIRE DATE	NUMBER OF PAY PERIODS (CIRCLE ONE): **12 / 11 / 10**