



## Election Form & Salary Reduction Agreement July 1, 2009

### Section 1. Employee Information

Employee Name: \_\_\_\_\_ SS# \_\_\_\_\_ Staff ID Number: \_\_\_\_\_

### Section 2. ELECTION of Benefits

**I request that my annual salary be reduced as follows:**

2-A)  I ELECT to pay my required contributions for the following coverage(s) on a **pre-tax** basis under the Plan:

- Group Medical Insurance
- Group Dental Insurance
- Vision Plan Protection (Voluntary Benefit through AFLAC)
- Cancer Protection (Voluntary Benefit through AFLAC)
- Accident Protection (Voluntary Benefit through AFLAC)
- Hospital Protection (Voluntary Benefit through AFLAC)
- Hospital Intensive Care Protection (Voluntary Benefit through AFLAC)
- Supplemental Life Insurance (CONTRIBUTIONS MADE WITH POST-TAX DOLLARS)

2-B)  I elect to participate in the health care reimbursement (HCR) plan for the plan year indicated above.  
The amount I would like to contribute under this plan for the plan year is \$ \_\_\_\_\_.

**I understand that I cannot contribute more than \$2,500 for the plan year.**

3-B)  I elect to participate in the dependent care reimbursement (DCR) plan for the plan year indicated above.  
The amount I would like to contribute under this plan for the plan year is \$ \_\_\_\_\_.

**I understand that I cannot contribute more than \$5,000 for the plan year.**

If the amount indicated for the dependent care account exceeds \$2,500, I certify that:

I will file a joint Federal tax return with my spouse for the year; or  I am not married.

I certify that all information on this form is correct. I understand that any amount remaining in my account that is not used for eligible expenses incurred and paid for during the plan year will be forfeited in accordance with current plan provisions and IRS tax laws. Deductions are in effect for the full plan year and cannot be changed or stopped unless I experience a change in family or employment status.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

### Section 3. WAIVER of Participation

**Information on the following benefits has been made available to me and I DECLINE to participate in:**

- Pre-tax deductions of contributions for Group Medical Insurance
- Pre-tax deductions of contributions for Group Dental Insurance
- Pre-tax deductions of contributions for Vision Plan (Voluntary Benefit through AFLAC)
- Pre-tax deductions of contributions for Cancer Protection (Voluntary Benefit through AFLAC)
- Pre-tax deductions of contributions for Accident Protection (Voluntary Benefit through AFLAC)
- Pre-tax deductions of contributions for Hospital Protection (Voluntary Benefit through AFLAC)
- Pre-tax deductions of contributions for Hospital Intensive Care Protection (Voluntary Benefit through AFLAC)
- Post-tax deductions of contributions for Supplemental Life Insurance (Voluntary Benefit through AFLAC)
- Health Care Reimbursement (HCR) Account
- Dependent Care Reimbursement (DCR) Account

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date