

Sterling Community Unit School District #5 Flexible Benefits Plan Election Form/Salary Reduction Agreement

**This form must be completed and returned to Trish Rick in the District Office
no later than November 30, 2011.**

or (for new hires) within 31 days of the date you are eligible for benefits under this Plan.

Name:	Division/Location:
Address:	SSN:
Effective Date of Election:	Date of Birth:
	Pay Period: Bi-Weekly 24 Pay Periods for year-round employees 18 Pay Periods for 9-month employees

Note: Multiply your "per Pay Period" election amount by the number of Pay Periods in the Plan Year (see above) to calculate your annual election.

Election or Waiver of Health FSA, Dependent Care FSA Benefits under the Flexible Benefits Plan

I have reviewed the terms of the Sterling Community Unit School District #5 Flexible Benefits Plan (with Premium Payment and Health FSA, DCAP Components) ("the Plan") and elect to receive the following coverages under the Plan. I understand that an amount equal to the contributions for the coverages I have elected, for each pay period in the Plan Year, will be deducted on a pre-tax basis from each of my paychecks (unless another method is prescribed by the Plan Administrator) to pay for the coverages that I elect. I understand that I cannot change or revoke the Premium Payment, Health FSA or DCAP components of this Agreement as of any date prior to the next January 1st, unless a Change in Election Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the Change in Election Event, as described in the Plan.

Note: A separate election form is provided for the Premium Payment Benefit, for Health, Dental and/or Supplemental Health and Accident Insurance coverage, and is available at the Human Resources Department.

(Check all boxes that apply.)

- Health FSA Benefits**, under which I elect to establish a pre-tax account (annual minimum \$100) from which I will be reimbursed for my eligible Medical Care Expenses, up to an annual limit of \$5,000. I understand that a monthly administration fee of \$2.75 will be added to my payroll deduction on a schedule determined by the Plan Administrator.

My Health FSA election is: \$ per Pay Period X Pay Periods = \$ Annual Election.

- DCAP Benefits**, under which I elect to establish a pre-tax account (annual minimum \$100) from which I will be reimbursed for my eligible Dependent Care Expenses, up to an annual limit of \$5,000, (or \$2,500 if married filing separately)

My Health DCAP election is: \$ per Pay Period X Pay Periods = \$ Annual Election.

- Additional Debit Card(s)** are requested for my eligible dependent(s) listed below. (Note: Debit Cards will not be issued to dependents under the age of 18.)

Name of Dependent	Date of Birth	Social Security Number

- Waiver of Health FSA and Dependent Care Benefits under the Flexible Benefits Plan** (check box only if you have elected NONE of the benefit options listed above): I elect to waive pre-tax benefits for the Health FSA and Dependent Care FSA provided under the Plan.

I have read and agree to the terms of participation and to any applicable certifications set forth in this Agreement. Any previous election and agreement under the Plan relating to the same Benefits, including any prior Election Form/Salary Reduction Agreement, is hereby revoked.

Employee's signature

Date