# KETTERING CITY SCHOOLS 125 PLANS

**2019 Plan Year Benefit Election/Compensation Agreement Enrollment Form**

**• Health Care Premium Plan**

**• Dependent Child Care Assistance Reimbursement Account Plan**

**PLEASE COMPLETE THIS FORM AND RETURN IT TO THE TREASURER'S OFFICE**

Name: _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip _____

## 1. HEALTH CARE PREMIUM PLAN

**By separate enrollment form(s)**, I have elected medical and/or dental coverage. I understand I must authorize payroll reductions on a pre-tax and/or after-tax basis for any of the coverage(s) elected. I hereby authorize the Board to reduce my salary by the amount of any required contribution for the medical and/or dental coverage(s) by the method indicated below:

____ I elect to participate in the * pre-tax option **for the coverage(s) I have elected on separate enrollment form(s).** I authorize a reduction of my salary equal to the required contribution for the coverage(s) elected. I understand that once I make this election, my salary reduction [the required contribution for the coverage(s) I elected] must remain in effect for the entire Plan year unless I have a qualified "change in family status".

*(With this option you **do not** pay taxes on your premiums for health or dental)

____ I elect to participate in the after-tax option for the coverage(s) I have elected on separate enrollment forms. I authorize deductions from my salary equal to the required contribution for the coverage(s) elected. I understand that the deductions for this election will be taxable to me as if I had received them.

## 2. DEPENDENT CHILD CARE ASSISTANCE REIMBURSEMENT ACCOUNT PLAN

____ I elect to participate in the Dependent Child Care Assistance Reimbursement Account Plan.

Indicate the amount you wish to deposit in your account during 2019 (maximum amount for a couple filing jointly is $5,000; individual filing single is $2,500). The amount you elect will be spread equally over the pays you receive in 2019 beginning with the second paycheck in 2019.

Amount to be deposited $ _____. (Total Annual Amount)

____ I decline to participate in the Dependent Child Care Assistance Reimbursement Account Plan. I understand I will not be eligible to participate until the next Plan year.

I hereby agree my compensation will be reduced by the amount of any required contribution for the medical and/or dental coverage(s) and by the amount of any deposits to my dependent child care assistance reimbursement accounts. I understand that:

- I cannot change or revoke this benefit election/compensation agreement at any time during the Plan year unless I have a "change in family status". A "change in family status" includes marriage, divorce, death of spouse/child, termination of employment of spouse, or change in health coverage attributable to spouse's employment.
- This agreement will automatically terminate if the Plans are terminated or discontinued, or if I cease to receive compensation from the Board which, before reduction hereunder, is at least equal to twice the amount of the reduction.
- The Treasurer of the Board may reduce or cancel my compensation agreement in order to satisfy provisions of the Internal Revenue Code.
- The reduction in cash compensation for this election(s) is in addition to any other reductions under other agreements or benefit plans.
- Unused Dependent Child Care Assistance Reimbursement Account Plan amounts as of December 31, 2019 must be forfeited by the participant.

This agreement is subject to the terms of the Kettering City Schools' Plan as from time to time in effect, shall be governed by and construed in accordance with the Laws of Ohio, shall take effect as a sealed instrument under the Laws of Ohio, and revokes any prior election/compensation reduction agreement relating to the Plan.

_____ Signature

_____ Date