

**COLOMA COMMUNITY SCHOOLS
FLEXIBLE BENEFITS PLAN**

ELECTION FORM

FOR TEACHERS

Plan Year: September 1, 2009 through August 31, 2010

EMPLOYEE INFORMATION:

Name (print):	Social Security No.:	
Address:		
Position:	<input type="checkbox"/> Fulltime	<input type="checkbox"/> Parttime

Reason for completing this Election Form:

- New Employee** (election is effective on the day you become eligible to participate in the District's group health plan)

- Open Enrollment** (election is effective September 1, 2009)

- Change in Status** (election is effective on date of change) - A completed Change in Status form must be attached.

Section A Health Premium Pre-Tax Payments
--

This section of the Flexible Benefits Plan applies only to employees who are required to contribute to a premium, or portion of a premium, for individual and/or dependent coverage under Employer's health benefit plan.

I understand that I may choose benefits under either Plan A or Plan B, as provided in the collective bargaining agreement. Accordingly, I choose Plan _____ (indicate either "A" or "B").

If I choose Plan A, I elect to pay, on **pre-tax basis**, the applicable premium for the health coverage I elected through my Employer. I understand that my compensation will be reduced in equal amounts from my paychecks during the plan year according to the required premium contribution.

If I choose Plan B, I understand that I am waiving health coverage for myself and my dependents. Instead, I will receive additional compensation and/or MESSA insurance options with a total value of \$175.00 per month.

- Additional compensation of \$ _____ per month. I understand that the additional compensation will be subject to all tax withholdings.
- \$ _____ for Group Basic Term Life Insurance
- \$ _____ for Group Short Term Disability Income Insurance
- \$ _____ for Group Supplemental Life Insurance
- \$ _____ for Group Survivor Income Insurance
- \$ _____ for Group Hospital Confinement Indemnity Insurance (continued enrollment only - no new enrollees)

I understand that my election can only be changed during the plan year under the circumstances permitted by federal regulations (for example, a change in family status). The Business Office has more information regarding the events for which a mid-plan year election is permitted.

I also understand that if I do not make a new election during a subsequent open enrollment period that **my current election regarding the health premium pre-tax payments will be continued. However, I understand that the applicable premium for the health coverage will be adjusted to the current rate for that plan year.**

<p>Section B Medical Spending Account Maximum Election - \$2,500</p>

- I elect to reduce my pay and have the pay reduction credited to my medical spending account for the reimbursement of **qualified** medical expenses. I elect to reduce my compensation by \$ _____ for the plan year of September 1, 2009 through August 31, 2010. I understand that this pay reduction will be made in equal amounts from my paychecks during the plan year.

I understand that any balance remaining in my medical spending account will be forfeited after all qualifying medical expenses for the plan year have been paid.

- I do NOT elect to participate in the medical spending account.

**Section C
Dependent Care Spending Account
Maximum Election - \$5,000**

I elect to reduce my pay and have the pay reduction credited to my dependent care spending account for the reimbursement of **qualified** dependent care expenses. I elect to reduce my compensation by \$ _____ for the plan year of September 1, 2009 through August 31, 2010. I understand that this pay reduction will be made in equal amounts from my paychecks during the plan year.

I understand that any balance remaining in my dependent care spending account will be forfeited after all qualifying dependent care expenses for the plan year have been paid.

I do NOT elect to participate in the dependent care spending account.

**Section D
Acknowledgment**

I have received and read the Summary Plan Description for the **Coloma Community Schools Flexible Benefits Plan.**

I understand that my election can only be changed during the plan year under the circumstances described in the Summary Plan Description.

I understand that I must complete a new election form each plan year in order to have amounts allocated to my medical spending account and my dependent care spending account.

Employee's Signature

Date

This form is accepted and received by Coloma Community Schools.

District Representative

Date

ADMINISTRATIVE USE ONLY:

<input type="checkbox"/>	New Participant	<input type="checkbox"/>	Hire Date: _____
		<input type="checkbox"/>	Eligible Participation Date: _____
<input type="checkbox"/>	Current Participant	<input type="checkbox"/>	Open Enrollment Date: _____
		<input type="checkbox"/>	Change in Status Date: _____
<input type="checkbox"/>	Pay Date of 1 st Deduction: _____		
<input type="checkbox"/>	Deduction Amount: _____		

#887778v1-17197-1