Salary Redirection Agreement

Employer: County of Mendocino

Social Security Number:_____ Employee Number_____

Name (Last): _____ (First) _____(Middle Initial)_____

Address: _____ City/State: _____ Zip: _____

On a separate benefit enrollment form(s), I have enrolled for certain insurance coverage(s) and understand that an amount equal to the total amount of premium and/or contribution for coverage(s) (including Medical and Dependent Care FSA plans) elected less any nonelective employer contribution allocable thereto will be withheld from my salary, continuing for each pay period until this agreement is amended or terminated. The amount of my required contribution is set forth on a schedule that has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. I understand that my actual take-home pay may be higher or lower depending on the coverage I select. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

Check the desired option for your Health Insurance Premium: ☐ **Pre-Tax** ☐ **After-Tax**

Complete the following elections only if participating in a Medical or Dependent Care Flexible Spending Account (FSA) Plan:

Medical FSA Plan: ($_____ per pay period) x (26 pay periods) = $_____ Annual Election

Dependent Care FSA Plan: ($_____ per pay period) x (26 pay periods) = $_____ Annual Election

If a rate change is brought on by a Company, the premium increase or decrease can be deducted pre-tax.

Check the desired policies you would like premium pre-tax below:

AFLAC- ☐ **Pre-tax** ☐ **After-tax** ☐ **Other- Pre-tax** ☐ **After-tax**

I understand and agree that (Initial in boxes.):

☐ On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a "change in status" occurs (as defined under the IRS Code), and the change is caused by and consistent with the "change in status". I understand that I cannot revoke any pre-tax election based on a Right to Examine Provision as may be contained in any insurance plan or policy issued to me.

☐ Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or policies. New coverage will not become effective until the first day of the plan year. The terms, conditions and the actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. Elections under the Medical and Dependent Care FSA plans will not continue without my completing and submitting a new Salary Redirection Agreement prior to the beginning of each plan year.

☐ Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverage may be funded on an after-tax basis to preserve the excludability of policy benefits.

(Initial if you are participating in either Medical or Dependent Care FSA Plans)

☐ FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANTS: I verify that I have received a summary of the tax rules, operational guidelines and reimbursement procedures for use in Medical and Dependent Care FSA plans. I understand the plan document will control notwithstanding any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify the employer if I receive reimbursement for an expense that does not qualify. I also agree, upon demand, to indemnify and reimburse the employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for non-qualified expenses, up to the amount of additional tax owed by me. Furthermore, I understand that any account surplus exceeding $500.00 in my Medical FSA account at the end of the plan year shall be retained by the employer to offset administrative expenses or future costs. The obligation to make reimbursements is the responsibility of my employer and not any service provider hired by the employer to assist in processing claims. I understand that I may be responsible for a monthly service fee for Medical and Dependent Care FSA plans and authorize my employer to payroll deduct any required service fee amount.

☐ **WAIVER OF PRE-TAX PREMIUMS UNDER THE FLEXIBLE BENEFITS PLAN: I ELECT TO WAIVE ALL PRE-TAX BENEFITS UNDER THE PLAN.**

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. I understand that certain benefits may be elected on an after-tax basis. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

Employee Signature: _____ **Date:** _____

Copy – White (Payroll) Yellow (Employer) Pink (Employee)