WACHUSETT REGIONAL SCHOOL DISTRICT
MASSACHUSETTS HEALTH CARE REFORM
PREMIUM-ONLY SECTION 125 CAFETERIA PLAN

Employee Waiver/Election and Compensation Redirection Agreement

This form allows the District to deduct your health insurance premiums pre-tax.

Please complete both sides and return to Human Resources with your Health Insurance Enrollment form.

EMPLOYEE NAME: _____

Plan Year: 2021 through 2022

☐ **Election of Pre-Tax Benefits**

I understand that an amount equal to the annual contributions for the coverage I have elected, divided by the number of pay periods 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 coverage that I elect.

☐ **Election of Medical Care Coverage**

On a separate enrollment form(s), I have enrolled in medical care coverage and I have received a schedule showing my share of the contributions for such coverage.

☐ **Waiver of Pre-Tax Benefits**

I elect to waive all pre-tax benefits under the Section 125 Cafeteria Plan:

I understand that if I have enrolled for medical care coverage on a separate benefit enrollment form, I will pay the required contribution with after-tax payroll deductions. I understand that I cannot elect pre-tax benefits except and until as described below and any after-tax medical care coverage is outside the Plan.

Prior to each Plan Year I will be offered the opportunity to make a new benefit election for the coming Plan Year. If I do not complete and return a new enrollment form at that time, I will be treated as having elected to continue this election to waive participation as indicated above.

** The Compensation Redirection may not be effective for any pay period that begins before this form is completed and returned to the Plan Administrator **

PLEASE TURN OVER ….

BE SURE TO SIGN BACK PAGE

In accordance with my rights under the Plan, I authorize salary reductions in the amount of current premiums being charged for the medical care coverage I have elected as follows:

- ❑ BCBS of MA – HMO Blue New England Options Monthly Premium _____
- ❑ BCBS of MA – HMO Blue New England Enhanced Value Monthly Premium _____
- ❑ BCBS of MA – Blue Care Elect PPO Monthly Premium _____

I understand that:

- If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reductions will automatically be adjusted to reflect that increase or decrease.
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefits programs maintained by my employer.
- Pre-tax contributions are not subject to federal income or Social Security ("FICA") taxes. This could result in reduction in the Social Security benefits I receive at retirement if I earn less than the annual FICA "taxable wage base" ($132,900 for 2019).
- Prior to the first day of each Plan Year I will be offered the opportunity to make a new benefit election for the coming Plan Year. If I do not complete and return a new enrollment form at that time, I will be treated as having elected to continue this benefit election for the new Plan Year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the benefit option for the new Plan Year.
- This Agreement is subject to the terms of the employer's Section 125 cafeteria plan, as amended for time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan.

_____ _____

Employee Signature **Date** **WRSD Representative Signature** **Date**