# Peralta Community College District Flexible Benefit Plan

Election Form And Salary Redirection Agreement

**Name**: _____ **Social Security Number**: _____

**Address**: _____ **Date of Birth**: _____

**City**: _____ **State**: _____ **Zip Code**: _____ **Daytime Phone**: _____

**Sex**: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married **Owner/Corporate Officer** ☐ Yes ☐ No

**Annual Salary Range**: ☐ 0 - $30,000 ☐ $31,000 - $64,000 ☐ $65,000 - $84,000 ☐ over $85,000

**Dependents Names / Relationship / Dates of Birth**: _____

_____

**New Hires Only:** Date of Hire: _____ Date of Eligibility: _____ Date of First Contribution (payroll date): _____

**If you wish to participate in any portion** of the flexible benefit plan **you must complete the following section.** You may elect to participate in one, or any combination of, the three benefits out lined below.

## ☐ I ELECT TO PARTICIPATE IN THE PLAN.

I authorize my employer to reduce my salary by the amounts indicated below.

**1.** **COMPANY SPONSORED INSURANCE PREMIUMS *(check one)*** ☐ **YES** ☐ **NO**
I understand the premiums (for the insurance benefits I have enrolled in) will be automatically calculated and any portion that is my responsibility to pay will be deducted from my paycheck each month before taxes are calculated on my wages.

**2.** **MEDICAL REIMBURSEMENT ACCOUNT (annual maximum of $2500 each plan year)** ☐ **YES** ☐ **NO**
This includes all eligible health related expenses not covered by my health insurance or any other benefit plan for me and my dependents. *This account does NOT cover any type of Insurance Premiums.*

**I elect $_____ as my ANNUAL Medical Reimbursement election**

| *For office use only* $_____ / _____ = _____ |
|---|
| *annual election* / *remaining pay periods* = *per paycheck contribution* |

**3.** **DEPENDENT DAYCARE ACCOUNT** ☐ **YES** ☐ **NO**
*This account may not exceed $5,000* if you are single or married and file a joint return, or $2,500 if you are married and file a separate return. Only dependent children under age 13 (unless physically or mentally handicapped) and/or a dependent adult requiring daycare qualify. And only for the hours when you and your spouse (if any) are at work.

**I elect $_____ as my ANNUAL Dependent Care election**

| *For office use only* $_____ / _____ = _____ |
|---|
| *annual election* / *remaining pay periods* = *per paycheck contribution* |

## ☐ I DECLINE TO PARTICIPATE IN THE PLAN.

I have been offered the opportunity to have pre-tax deductions from my salary. I have declined to have any pre-tax deductions at this time. I understand that by declining, any portion of company sponsored insurance premiums that I am required to pay out of my own pocket will be an after-tax deduction from my salary. I also understand that I will not be allowed to change this declination until the beginning of the next plan year unless I experience a qualified change in my family status.

**I understand that** I cannot change this election during the plan year unless I undergo a change in family status. Any unused funds left in my account at the end of the plan year are forfeited. If I terminate my employment, whether voluntarily or involuntarily, and do not elect to COBRA my Medical Reimbursement Account, I can only submit expenses incurred prior to my termination date. My Social Security Benefits/Disability may be affected by this election. I cannot claim a tax credit for any expenses paid for by this Plan. If I elect to participate in the Dependent Daycare Account I must file IRS Form 2441 with my tax return. This election replaces any prior elections and will terminate at the end of the plan year, or if this plan is terminated.

Signature _____ Date _____

Return this completed form to your Benefits/ Human Resources Representative