Montrose County – 2019 Plan Year
Sec. 125 Cafeteria Plan Premium Reduction Option *Plus* FSAs
Benefit Election Form and Salary Reduction Agreement

Employee Name (Last, First, MI) Social Security No.

Employee Mailing Address Phone #

Annual Salary Hire Date

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown under the Premium Conversion and Reimbursement Accounts headings shown below and to deduct from after-tax income the post-tax items shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date the Plan. I further authorize future adjustments in the amount of the salary reduction in the even the cost of coverage in any problem selected below under the heading PREMIUM CONVERSION is changed by the carrier during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction or after-tax deduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit (All amounts paid should be per deduction period) **Salary Reduction per Pay Period**

Premium Conversion

Medical ..... $_____

Dental ..... $_____

Vision……..$_____

Supplemental Life (Max $50,000)…… ..$_____

GAP insurance…….$_____

Pretax Deduction for Insurance Premiums.....$_____

Reimbursement Accounts

FSA Medical Expenses..... $_____

FSA Dependent Care..... $_____

Pretax Deduction for Reimbursement Accounts .....$_____

Total Deductions……...$_____

I have read the Summary Plan Description and the attached Plan Information Summary Montrose County has given me.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as listed on the Status Change Matrix I received with the Summary Plan Description.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate.**

Signature_____ Date_____

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate.**

Signature_____ Date_____