WEST HEMPSTEAD UNION FREE SCHOOL DISTRICT

FLEXIBLE BENEFITS PLAN

ENROLLMENT FORM

Please print or type:

____

Last Name First Name Middle Initial

____

Street Address City State Zip Code

____

Social Security Number Employee Number

The amount by which your salary will be reduced will be the amount of the Health/Dental premiums for your particular medical coverage. This includes dental and excess medical premiums.

Please indicate type of coverage: Individual Coverage ______ Family Coverage ______

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Read the statements below. If you wish to enroll, sign and date this form and return to **Karine Yenque** in the **Payroll Dept.** Form is due by **December 9, 2020** for January 1, 2021 effective date. **For new employees, form is due as soon as possible.**

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I authorize the reduction of my salary on a per pay check basis during the portion of the year remaining after the date of this agreement, for the amount of the applicable premiums deducted for Health/Dental (Medical) Insurance.

I understand that this authorization is irrevocable until the next election period unless I have a change in family status (i.e., marriage, divorce, death of spouse or child, birth or adoption of a child, termination of employment of a spouse, switch from full-time to part-time or vice versa or such other events as the Plan Administrator determines will permit a change or revocation).

This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the District.

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

If my required contributions for the Individual or Family Medical Plan are increased or decreased while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease.

Prior to January 1 each year, I will be offered the opportunity to cancel my compensation reduction for the following 12-month period. If I do not cancel in writing at that time, this compensation reduction agreement will automatically renew January 1.

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

This agreement is subject to the Terms of the West Hempstead Union Free School District Flexible Benefits Plan as from time to time in effect, shall be governed by and construed in accordance with the laws of the State of New York, shall take effect as a sealed instrument under the laws of the State of New York, and revokes any prior compensation reduction agreement relating to the Flexible Benefits Plan.

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Employee's Signature Date

Accepted and agreed to by West Hempstead Union Free School District

By: ____

Date