
TOWN OF WINCHENDON
TOWN OF WINCHENDON - SECTION 125 CAFETERIA PLAN

**Section 125 Cafeteria Plan
Employee Waiver /Election Form/
Compensation Reduction Agreement**

This form must be completed when an employee elects to either a) waive all pre-tax benefits or b) enroll in a pre-tax benefit deducted from their compensation for their medical care coverage premium amount.

TOWN OF WINCHENDON

Employer Name (Legal Entity Name)

Employee Name (First, Middle Initial, Last)

Employee Address

Employee Social Security Number

Employee Number/ID

Plan Year _____ July 1, 2022 _____ through _____ June 30, 2023 _____

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.

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 For 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.

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:

Medical Care Coverage _____ Premium per Month \$ _____
(Enter Connector Seal of Approval Plan Name from Enrollment Form)

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 a reduction in the Social Security benefits I receive at retirement if I earn less than the annual FICA “taxable wage base” (\$97,500 for 2007).
- 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

Accepted and agreed to by the Employer’s

Authorized Representative

Date