The Public Schools of Petoskey

CAFETERIA PLAN OPEN ENROLLMENT

Plan Year 01/01/18 to 12/31/2018

BENEFITS PLAN ELECTION FORM

NAME: ______________________________

Enter Name: First, Last

EFFECTIVE DATE: **JANUARY 1, 2018**

A new election form must be on file every plan year, even if no changes are made to your current insurance.

Choose carefully: No changes are allowed during the plan year unless you have a *Change in Family Status* as defined in the Petoskey Schools Cafeteria Plan.

CHOOSE ONE OPTION:

Option A: Health Plan

☐ I elect to participate in the group health plan made available by the Public Schools of Petoskey, and agree to complete any necessary enrollment forms. If I am required to pay a portion of this coverage, I understand this deduction will be on a pre-tax basis. **Choose ONE of the plans below:**

☐**PAK A: MESSA ABC Plan, No Co-insurance, ABC Rx**

☐**PAK C: MESSA ABC Plan, 10% Co-insurance, Mail Rx**

Option B: Cash in Lieu of Insurance

☐ I waive health coverage for myself and my dependents under the group health plan made available by Public Schools of Petoskey. I understand there are potential penalties from the I.R.S. if I receive Social Security and/or Medicare benefits during the same months as I receive cash-in-lieu payments. Instead of Health coverage, I understand I will receive additional compensation as follows:

- The amount of additional compensation is determined by the Board policy.
- The additional compensation will be paid in equal periodic installments during the plan year.
- The additional compensation will be subject to all required tax withholding.
- The additional compensation is not reportable retirement compensation in most cases.

Signature: **X**___________________________________ Date: _______________

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WAIVER OF HEALTH INSURANCE

NOTE: This form is only for those who elect cash-in-lieu benefits.

Please read carefully and sign and date on the reverse side

1. Introduction.

I, ____________________________ the undersigned, am an Employee of the Public Schools of Petoskey (the "Employer").
Enter Name: First, Last

In accordance with the terms of my employment with the Employer, and the Public Schools of Petoskey Cafeteria Plan (the "Plan"), I have elected to waive coverage, for me and my dependents, under all health insurance programs of the Employer. **My waiver is knowing and voluntary.** Under the terms of the Plan, the terms of my employment, and this Agreement, the Employer is willing to permit me to waive health insurance coverage under the Employer's health insurance program.

2. Waiver of Participation.

In accordance with the Plan, for myself and my heirs, assigns, successors, spouse and dependents, I hereby waive any right on my part and the part of my spouse and dependents to participate in any and all health insurance programs maintained by the Employer. For purposes of this waiver, "health insurance programs" means medical insurance. Other insurance benefits, to the extent that they are available to me notwithstanding this waiver (including dental, vision, life, and long-term disability insurance) will not be waived. In making this knowing and voluntary waiver, I, on behalf of myself and my spouse and dependents, understand and agree that we will have no coverage or benefits whatsoever under any of the Employer's health insurance programs, and that this waiver may not be revoked, except to the extent permitted under the Plan. My waiver of health insurance is effective only for the first Plan Year after the date of this Waiver (or within which this Waiver is executed, if the signing person has become eligible to participate in the Plan on a date other than the first day of a Plan Year). If my spouse is an Employee of the Employer, this Waiver does not affect my spouse's right to receive Benefits under the Plan, in accordance with the terms of my spouse's employment with the Employer.

3. Release and Indemnification.

I, ____________________________ for myself and my heirs, assigns, successors, spouse and
Enter Name: First, Last

dependents, covenant and agree that I will not make any claim under any of the Employer's health insurance programs for medical expenses that I incur during the Plan Year that this Waiver is in effect (even if I receive bills for those expenses after the end of the Plan Year), and I fully release the Employer, the Administrator, and all agents of each of them, and all insurers under policies maintained by the Employer from providing me health insurance coverage during the Plan Year, from any liability arising in connection with any claim by me, or my spouse or dependents during the Plan Year, or for any benefits or coverage during the Plan Year under any of the Employer's health insurance programs; and I, for myself and my heirs, assigns, successors, spouse and dependents, agree to defend and indemnify the Employer, the Administrator, and all agents of each of them, from any liability, loss, damages, costs or expenses (including but not limited to attorney's fees) arising in connection with this Agreement, or any claim for benefits or coverage under any of the Employer's health insurance programs.

4. Acknowledgments.

Except in the case of a permitted election change, as defined in Section 4.3 of the Plan, I acknowledge and agree that my election to enter into this Agreement and waive coverage under the Employer's health insurance programs is: (i) irrevocable during the Plan Year for which it is made; (ii) knowing and voluntary; and (iii) with full understanding of all the provisions of this Agreement.

5. Tax Consequences.

No representations have been made to me by the Employer as to any possible tax consequences of this Agreement and the Employer shall have no liability with regard to any such tax consequences. I am not relying on the Employer for any tax advice.

6. Applicable Law.

This Agreement will be construed in accordance with the laws of the State of Michigan.

CERTIFICATION:

I am covered under another group health plan not offered by the Public Schools of Petoskey (through spouse, self, parent, etc.):

Carrier Name: _________________________ Policy/Contract Number: ____________________

Policyholder Name: ___________________ Relationship to Employee: ___________________

☐*Please check if Carrier Coverage indicated is through Marketplace Exchange.*

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (MEDICAL ONLY)

Signature: **X**_____________________________________ Date: _____________

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SALARY REDUCTION AGREEMENT

_________________________ _________________________

Enter Name: First, Last *Last 4-digits of SSN*

____

Enter Street Address, State, Zip

THIS SALARY REDUCTION AGREEMENT is entered into on the date shown below by and between The Public Schools of Petoskey (the "Employer") and you, the Participant named above.

1. **Introduction**. The Employer is the sponsor of The Restated Public Schools of Petoskey Cafeteria Plan (the "Plan"), a copy of which is available to you upon request to the Administrator. The Plan is intended to be a cafeteria plan within the meaning of Section 125 of the Internal Revenue Code (the "Code"). You are entering into this Agreement with the Employer for the purpose of participating in the Plan and to reduce your salary in order that you may receive benefits under the Plan.

2. **Participation**. You agree to participate under the Plan and to reduce your salary by the aggregate of the amounts shown below for the various benefits that you have elected to receive:

Description of Benefit –CHOOSE ONE	Your Contribution:
☐ **I choose not to participate in the District Flexible Benefits Plans (Healthcare Flex Spending or Dependent Care Spending).** If you check this box, skip the rest of the options listed below (and reverse). See other side for signature.	
OR	
☐ **Healthcare Flexible Spending Account- Uninsured Healthcare Expenses (*Employees not covered by a Health Savings Account, ONLY*).** I elect to have the amount which I have indicated in the box to the right credited to a Health Care Reimbursement Account for me. I understand that the amount that I select may not be more than **$2,650** for the Plan Year. Further, I understand that any amount that I allocate to this Benefit that is not used by the end of the Plan Year (plus the Grace Period) will be forfeited.	**Amount per pay:** **For 20 pays** **= Total Plan Year Contribution**
OR	
Limited Purpose Health Flexible Spending Account Plan (For Employees covered by or expecting to be covered a Health Savings Account plan). I elect to have the amount which I have indicated in the box to the right credited to a Health Care Reimbursement Account for me to pay for **Eligible Medical Expenses, including dental, vision and any other expenses permitted under Internal Revenue Code Section 223**. I understand that the amount that I select may not be more than **$2,650** for the Plan Year. Further, I understand that any amount that I allocate to this Benefit that is not used by the end of the Plan Year (plus the Grace Period) will be forfeited.	**Amount per pay:** **For 20 pays** **= Total Plan Year Contribution**
OR	
☐ **Health Savings Account Contributions.** I elect to have the amount which I have indicated in the box to the right contributed to my HSA. I understand that the amount may not be more than the statutory limit ($**6,900** or $**3,450** or single subscribers) reduced by the amount of the contributions that the Employer will make on my behalf, and prorated based on the number of months during the year that I am eligible to participate in a HSA. Further, I understand that once these amounts are contributed to an HSA on my behalf, the Employer shall have no authority or control over those funds. ***Certification:*** *By electing HSA contributions, I am certifying that I meet the requirements under I.R.S Code § 223 to be eligible to contribute to an HSA. (For more information about HSA eligibility requirements, see IRS Publication 969.) All contributions through the Employer's payroll system will be designated to* Health Equity *as the HSA trustee/custodian.* ***Please see reverse for signature and dependent care information ➔***	**Amount per pay:** ☐ **20 Pays OR** ☐ **26 Pays** **= Total Plan Year Contribution**

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☐ **Dependent Care Assistance.** (Applies to all employees). I elect to have the amount which I have indicated in the box to the right credited to a Dependent Care Reimbursement Account for me. I understand that the maximum amount which can be credited to my account for the Plan Year is the lowest of: (a) $5,000 ($2,500 if I am married and I file a separate federal income tax return), b) my earned income for the year (after reduction for dependent care assistance), or (c) my spouse's actual or deemed earned income (See the Summary Plan Description for an explanation of these rules). Further, I understand that any amount that I allocate to this Benefit that is not used by the end of the Plan Year will be forfeited.	Amount per pay: For 20 pays = Total Plan Year Contribution

3. **<u>Duration.</u>** The reduction of salary described in paragraph 2 shall be effective as of January, 2018, as to compensation not yet earned as of that date, and shall continue, subject to modification only as permitted under the Plan, until the earlier of (a) the last day of the Plan Year for which this Agreement has been entered in to by you and the Employer; or (b) you becoming ineligible to participate in the Plan, such as by virtue of your termination of employment with the Employer.

4. **<u>Handling of Deferred Amounts</u>**. The Employer agrees that all amounts deferred under this Agreement will not be paid to you but will be credited by the Employer to the accounts maintained on your behalf under the Plan. With respect to deferred amounts **other than HSA contributions**, all amounts credited under this Plan will remain the sole property of the Employer, and will not be held in trust for you or as collateral security for the fulfillment of the Employer's obligations under the Plan. All amounts credited under this Agreement shall be subject to the claims of all general creditors of the Employer, and neither you nor any of your Beneficiaries shall have a secured or preferred position with respect to any of those amounts, or have any claim against the Employer except as a general creditor. Notwithstanding the foregoing, your HSA contributions shall be paid to the HSA trustee/custodian of the HSA owned by you and established and maintained outside of the Plan, and your trustee/custodian will hold those contributions solely for your benefit. Neither the Employer nor its creditors have any authority or control over the funds contributed to your HSA.

5. **<u>Modification</u>**. Prior to each Plan Year, you will be given the opportunity to make elections under the Plan for the new Plan Year**. If you do not elect to contribute any funds to the Benefits described herein, then you will not be able to seek reimbursement of eligible expenses from those Benefit accounts.** Except as provided in the limited "Permitted Election Changes" section in the Plan, this Agreement may not be revoked or amended.

6. **<u>Preservation of Plan Status</u>**. The Employer may, unilaterally and without prior notice to you, reduce the amount computed under paragraph 2 if, in the sole judgment of the Employer, a reduction is necessary to continue the favorable status of the Plan, or any of its constituent plans, under the discrimination rules of the Code and related regulations.

7. **<u>Pay-out of Benefits</u>**. Amounts credited to your accounts will be distributed only in accordance with the terms of the Plan in effect at the time of the distribution.

8. **<u>Forfeiture of Unused Amounts</u>**. Any amounts remaining in your Flexible Benefits accounts under the Plan at the end of the Plan Year will be forfeited and will remain the property of the Employer. Amounts that remain in your HSA accounts are not forfeited and carryover to the next year.

9. **<u>Employer not Liable</u>**. By providing Employees with the opportunity to elect coverage under this Plan, the Employer is not assuming liability for any of your medical expenses of any nature.

10. **<u>Incorporation of Plan</u>**. The terms and conditions of the Plan are hereby incorporated by reference into, and made a part of, this Agreement, as if fully set forth in this Agreement.

11. **<u>Acknowledgments</u>**. You hereby acknowledge that you have received a copy of this Agreement, and either received, or had an opportunity to receive, a copy of the Plan; that you have read this Agreement, and either read, or had an opportunity to read, the Plan; that by signing this Agreement you are voluntarily electing to participate in the Plan; that neither this Agreement nor the Plan constitute an agreement for continued employment.

PARTICIPANT'S SIGNATURE	**THE PETOSKEY PUBLIC SCHOOLS**
___________________________________	By: *Kent Cartwright*
Date: ______________	Its: Chief Financial Officer