MSAD 35 Staff

Premium Only

ANNOUNCEMENT MEMO FOR FLEXIBLE BENEFITS PLAN

MSAD 35 has established a special program that will offer tax savings for all employees who wish to take advantage of it. The Plan is called a FLEXIBLE BENEFITS PLAN and is permissible under Internal Revenue Code Section 125.

WHAT IS A SECTION 125 PLAN?

It is a method of reducing income taxes. If you are enrolled in the unit's group health insurance programs, and must contribute a portion of the monthly premiums, you now pay income taxes (federal, state and social security) on the amount that you contribute. Under this new program, however, your contribution is not taxed.

The Dependent Care Reimbursement Account allows you to pay certain dependent care expenses with tax-free dollars. In other words, you do not have to pay federal, state, and FICA taxes on these earnings that are designated for dependent care reimbursement.

The Medical and Dental Care Expense Reimbursement Account allows you to pay for your healthcare expenses with tax-free dollars when they are not otherwise covered by a medical insurance Plan.

For example, for a single employee taking only 1 (one) exemption:

	gross weekly pay............$370.00
[Present method]	federal and state
	withholding (on $370) 63.00
	insurance deduction 14.00
	Dependent Care Exp. 70.00
	NET PAY.................$223.00
	gross weekly pay............$370.00
	insurance deduction 14.00
[New method]	Dependent Care Ded..........70.00
	federal and state
	withholding (on $286) 46.00
	NET PAY.................$240.00

In the above example, the savings would be $17 a week or $884 a year. Obviously, each employee's savings will depend upon several factors, including the type of coverage elected (single, family, low option, high option, etc.) and tax bracket.

YOU ARE NOT REQUIRED TO PARTICIPATE in this program. If you decide to sign up, however, (and if you are subject to Social Security withholdings) you must understand that while you will save money by having your contribution deducted tax free, you may have slightly less money contributed to your Social Security account.

You may wish to talk with your accountant or personal tax advisor before you decide. In any case, be sure to read the SALARY REDUCTION AGREEMENT form carefully. If you decide to take advantage of this program, please fill out the form, sign it and return it to the central office. In the meantime, if you have any questions, feel free to call Sue Berg at the business office.

MSAD 35 Staff
FLEXIBLE BENEFITS PLAN
ELECTION FORM AND
SALARY REDUCTION AGREEMENT

I, ___________________________________, have been informed of my right to participate in the MSAD 35 Staff Flexible Benefits Plan (the "Plan").

With respect to Plan benefits for the period 7/1/2018, through 6/30/2019, I hereby make the following elections, pursuant to Article IV of the Plan:

[ ] A. I have enrolled for Medical Benefit Coverage and I elect to receive my medical coverage under the MSAD 35 Staff Flexible Benefits Plan. Any previous election and compensation reduction agreement under the Flexible Benefits Plan relating to the same benefits is hereby revoked. I authorize the Employer to make aggregate payroll deductions in the amount of my required contributions for the benefit option I have elected under the Flexible Benefits Plan, in equal installments.

[ ] B. I have enrolled for Dental Benefit Coverage and I elect to receive my dental coverage under the MSAD 35 Staff Flexible Benefits Plan. Any previous election and compensation reduction agreement under the Flexible Benefits Plan relating to the same benefits is hereby revoked. I authorize the Employer to make aggregate payroll deductions in the amount of my required contributions for the benefit option I have elected under the Flexible Benefits Plan, in equal installments.

[ ] C. I do not elect to participate in the Flexible Benefits Plan at this time and thus no payroll deductions for the above purposes shall be made.

I recognize that the above election(s) is (are) irrevocable for the period stated above (except as may be allowed by IRS regulations) and that I will not be entitled to receive any nonelective portion of the amount(s) specified above as cash compensation.

Dated __________________ Signature ____________________________________

OFFICE USE ONLY

CIRCLE ONE:
INITIAL ELECTION NEW EMPLOYEE FAMILY STATUS CHANGE

DESCRIBE THE FAMILY STATUS CHANGE: ___________________________________
DATE OF FAMILY STATUS CHANGE: ____
DATE RECEIVED: ____
RECEIVED BY: ____

REIMPEL 2001