PPS Teacher Personnel Cafeteria Plan
MEDICAL AND DEPENDENT CARE REIMBURSEMENT
ELECTION FORM AND
SALARY REDUCTION AGREEMENT

NAME:____
SOCIAL SECURITY NUMBER:______________________
ADDRESS:___________________________________

I have been informed of my right to participate in the PPS Teacher Personnel Cafeteria Plan Flexible Benefits Plan (the “Plan”).

With respect to Plan benefits for the period September 1, 2021, through August 31, 2022, I hereby make the following elections, pursuant to Article IV of the Plan. **Please note if you are enrolling for the first time your plan year may be pro-rated according to your start date. Also, you are not eligible for the rollover option listed below until you enroll for a second consecutive year.**

[ ] A. I elect to participate in the PPS Teacher Personnel Cafeteria Plan Dependent Care Assistance Plan, and I desire the Employer to use $______________ of my compensation during the period stated above as a fund available to provide benefits for me under such Plan. I authorize the Employer to make aggregate payroll deductions in the amount stated above, in equal installments, for such purpose. I understand that an administration fee of $4.00* a month will be deducted from my paycheck in addition to my contribution to the Dependent Care Assistance Plan.

[ ] A.1 I do not elect to re-enroll in the Dependent Care Assistance Plan but would like the remainder of my funds rolled over into the 2021-2022 plan year. I understand there will be an administration fee assessed to any funds rolled over if I do not elect to enroll in the 2021-2022 plan year.

[ ] B. I elect to participate in the PPS Teacher Personnel Cafeteria Plan Medical and Dental Care Expense Reimbursement Plan, and I desire the Employer to use $______________of my compensation during the period stated above as a fund available to provide benefits for me under such Plan. I authorize the Employer to make aggregate payroll deductions in the amount stated above, in equal installments, for such purpose. Any unused funds from my prior plan year will automatically will rollover into this plan year. Two debit cards will be provided to me at no cost on or around the start of my plan year. I understand that an administration fee of $4.00* a month will be deducted from my paycheck in addition to my contribution to the Medical and Dental Care Expense Reimbursement Plan.

[ ] C. I do not elect to re-enroll in the Medical and Dental Care Expense Reimbursement Plan at this time and thus no payroll deductions for the above purposes shall be made, **however:**

[ ] I **elect** to have all unused funds from the 2020-2021 plan year rolled over into this current plan year. I understand there will be an administration fee assessed to any funds rolled over if I do not elect to enroll in the 2021-2022 plan year.

[ ] I **do not elect** to rollover any funds leftover from the 2020-2021 plan year because there will not be sufficient funds to cover the administrative fee that is assessed.

[ ] D. I do not elect to participate in the Medical and Dental Care Expense Reimbursement Plan at this time.

*The administration fee deduction will be a total of $6.00 a month for persons electing both Plans.

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 non-elective portion of the amount(s) specified above as cash compensation.

Dated ___________________ Signature _____________________________________

OFFICE USE ONLY:

INITIAL ELECTION NEW EMPLOYEE FAMILY STATUS CHANGE
DESCRIBE FAMILY STATUS CHANGE: ____