

**Cook County School District 130**  
**Employee Benefit Election Form and Salary Reduction Agreement**

Section 125 of the Internal Revenue Code allows participants in Cook County School District 130's Flexible Benefit Plan to save taxes by electing to pay their share of premiums for certain insurance coverages on a pre-tax basis. These elections are called "Deferral Contributions" in the Plan. This election form specifies which benefits you choose to participate in this plan. Amounts will be deducted in equal amounts during each pay period. Your election will remain in place from year to year unless the employee notifies the employer in writing.

Employee Name: \_\_\_\_\_ SS#: \_\_\_\_\_

**DEFERRAL CONTRIBUTION ELECTIONS**

<b>Insurance Type</b>	<b>Please check one of the boxes for each plan:</b>	
	I elect to pay my share of the premium to the following plans on a pre-tax basis	I do not elect to pay my share of the premium to the following plans on a pre-tax basis
Health Insurance		
Dental Insurance		
Vision Insurance		

With regard to my salary reduction agreement and election of benefits, I understand that:

1. I may not change elections during the Plan Year unless there is a change in my status (e.g. marriage, divorce, death of my spouse or child, adoption or birth of my child, termination of my employment or that of my spouse, or dependent(s), change in the status of a dependent because of age or student classification, a change in my residence, or a change in the residence of my spouse or dependent(s)).
2. The Plan Administrator is authorized to adjust the amount of my salary reductions and benefits if necessary to satisfy certain requirements of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
3. My election of salary reductions and benefits will remain in effect for future Plan Years unless I change them prior to the beginning of a Plan Year.
4. My Social Security benefits may be slightly reduced as a result of my election.
5. Signing this Agreement does not initiate my coverage under the health, dental or vision insurance plans. I must complete a separate enrollment form to start my health, dental or vision insurance coverage.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date