Payroll Effective Date: September 24, 2018

ESU 8 FLEX PLAN
ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT

To process your Election all personal information is required and is held strictly confidential

Employee No.: _____ (last 5 digits of SSN)

Employee Name: _____

Employee Address: _____ **City:** _____ **Zip:** _____
DOB: _____ **Social Security No.:** _____

Plan Year: **September 1, 2018 through August 31, 2019** Pay Periods (circle one): 12 10 9

In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected for the Plan Year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each pay period. I understand that this election is irrevocable during the Plan Year unless the revocation is on account of and consistent with a "change in family status." I understand that any amounts remaining in my account(s), not used for eligible expenses incurred during the Plan Year, will be forfeited and not returned to me.

Annual Amount	Per Payroll Amount	
		Medical Expense Reimbursements **No HSA** (maximum **$2,650.00** per employee)
		Medical Expense Reimbursements **With HSA** (maximum **$2,650.00** per employee)
		Dependent Care Assistance (maximum **$5,000.00** per family)
		* Health/Dental Insurance
		* AFLAC Insurance (total of all applicable policies)
		* Vision Insurance

* Employer-sponsored insurance plans

➔ **Employee signature** _____ **Date** _____

IF YOU DECLINE PARTICIPATION: I understand the benefits of the Flex Plan and I decline participation for the 2018/19 Plan Year.
Employee Signature _____ **Date** _____

By Educational Service Unit 8 _____

Please return to the ESU 8 Business Office by July 20th.