HELENA SCHOOL DISTRICT #1
CAFETERIA PLAN
ELECTION FORM PY 23-24

As an eligible employee in the above Plan, I acknowledge that I have received the Summary Plan Description/Coverage and understand the benefits available to me as well as the other rights and obligations which I have under the Plan**. I understand that if I do not complete my Enrollment through the EE Portal on or before the last date of open enrollment, there will be a lapse in coverage. In this case, the District will assume that participation in the District's Health Plan and other options are *declined*.**

The Employer and I agree that my cash compensation/salary can/will be reduced by the amounts set forth on the Cafeteria Benefits Selection Form Summary for each pay period and Plan year (or during such portions of the year as remains after the date of this agreement) in accordance to my choices.

I also understand that I must enroll every plan year if I wish to continue to be a participant in the Health Plan and reimbursement accounts of the Cafeteria Plan. This agreement is subject to the terms of the employer's cafeteria plan, as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan.

I also am aware that the Benefit Dollars awarded by the School District is pre-tax dollars meant to purchase a Health Plan. If I do not purchase a health plan, then *I will forfeit the Premium Single amount*.

OTHER TERMS AND CONDITIONS

I understand that I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan year unless I have a change in a Qualifying Event such as family status or, for accident or health coverage and group-term life, a change in status, and my election is consistent with such change.

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event it is believed advisable in order to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefits specifically for me in a later Plan year. Any reimbursement account amounts that are not used during a Plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later year.

Prior to the first day of each Plan year, I will be offered the opportunity to change my benefit elections for the upcoming Plan year. If I do not submit my new elections on-line or by form at that time, I will be treated as having elected not to participate for the upcoming Plan year in the reimbursement spending accounts.

ELECTION OF MEDICAL REIMBURSEMENTS

The annual Plan limit which may be allocated to the medical reimbursement account is $2,750. I understand that reimbursements will be available only for "qualifying medical care expenses". Generally, "qualifying medical care expenses" are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. This section of the agreement will automatically terminate if the Plan is terminated or discontinued.

If I cease my employment with the Employer, my participation in the Plan will continue. My salary redirections will continue with after-tax contributions for the remainder of the Plan year. I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction on my tax return.

ELECTION OF DEPENDENT CARE ASSISTANCE

The annual Plan limit which may be allocated to the dependent care assistance account is $5,000. I understand that reimbursement will be available only for "qualifying dependent care assistance expenses" as described in the Internal Revenue Code Section 129, the Plan Document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax owed by me. I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred. I agree to provide the Administrator with the name, address and, if applicable, the taxpayer identification number of the service provider.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan year. I will only be reimbursed for amounts up to the balance in my account at the time of my request. I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

IMPORTANT INFORMATION FOR EMPLOYEES COMPLETING THE CAFETERIA BENEFITS SELECTION FORM SUMMARY

1. **Benefit dollars are not to be figured into your gross annual wages.**
2. **MEDICAL/DENTAL/VISION (HEALTH PLAN)** - Any employee not enrolled in the district health insurance plan will have an amount equivalent to the single premium (or prorated portion for part-time employees) contributed directly to the health benefit plan and the employee will not receive that portion of the cafeteria benefit.
3. **GROUP LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT** – Employees working more than 15 hours must select either the $25,000 or $50,000 life insurance option. This benefit is not available for employees working less than 15 hours per week.