

**Brewster Central School District
Section 125 Benefit Plan
Enrollment Application**

Plan Year: January 1, 20 [__ __] - December 31, 20 [__ __]

Employee Name (Last, First, Middle Initial):				Building or Department:						
Street Address or PO Box #:				City:		St:	Zip (+4):	SS Number:		
Telephone (Home):		Telephone (Work with Extension):		Employment Year (Months)		Pay Schedule				
				<input type="checkbox"/> 10 Mo	<input type="checkbox"/> 12 Mo	<input type="checkbox"/> Specify	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Sem-Monthly	<input type="checkbox"/> Monthly

Medical Insurance Premium Plan (Check One):

- I am enrolled in the Brewster Central School District's Medical Insurance Premium Plan and elect to have my portion of medical premiums paid on a pre-tax basis, for this and subsequent years.
- I am enrolled in the Brewster Central School District's Medical Insurance Premium Plan but do **NOT** elect to have my portion of medical premiums paid on a pre-tax basis, for this and subsequent years.
- I have elected **NOT** to participate in the Brewster Central School District's Medical Insurance Premium Plan which entitles me to a cash allowance.

Personal Lifestyle Protector (Cancer) Insurance Plan (Check One):

- I elect to enroll in the Brewster Central School District's Personal Lifestyle Protector (Cancer) Insurance Plan and to have my portion of premiums paid on a pre-tax basis, for this and subsequent years.
- I elect to enroll in the Brewster Central School District's Personal Lifestyle Protector (Cancer) Insurance Plan but do **NOT** elect to have my portion of premiums paid on a pre-tax basis for this and subsequent years.
- I elect **NOT** to participate in the Brewster Central School District's Personal Lifestyle Protector (Cancer) Insurance Plan this plan year.

FLEXible Spending Accounts (Check One):

- I elect the following amounts to be withheld from my paycheck this plan year. I understand that I will **NOT** pay Federal, State Income, or FICA taxes on the amounts withheld.

For Payroll Office Use Only
of Pay Periods Per Pay Period

\$ _____	this plan year for the Unreimbursed Medical FLEX Account (minimum \$200; maximum \$3,000) <i>Note: No premiums (eg. COBRA) may be paid through this account.</i>	+ _____	= \$ _____
\$ _____	this plan year for the Dependent Day Care FLEX Account (up to \$5,000 or \$2,500 if married and filing separate tax returns) <i>Note: No kindergarten tuition may be paid through this account.</i>	+ _____	= \$ _____
\$ _____	this plan year for the Premium Expense FLEX Account (For privately held health insurances. No life insurance premiums may be paid through this account.)	+ _____	= \$ _____
\$ _____	Total withheld this plan year		

- I elect **NOT** to participate in the Flexible Spending benefit for this plan year.

Salary Redirection Agreement:

I have read and understand the explanation I have received regarding my options under the Brewster Central School District FLEXible Benefit Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. **I understand that I cannot change any of my elections during the plan year (unless I have a change in status), and that any money left in my account(s) at the end of the plan year will be forfeited.**

_____ Employee Signature	_____ Date	_____ Employer Signature	_____ Date
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Please Return to Payroll Office