To be completed by the Employer

____New Enrollment

____Open Enrollment Benefits effective on:_____

CAFETERIA PLAN
Salary Redirection Agreement ("SRA")

1. Employer Information

Employer Name: Barton County Community College Group Number: BMI179

Plan Year Start Date: 11/01/17 Plan Year End Date: 10/31/18

2. Employee Information

Employee Last Name: _____ First Name: _____ MI: _____

Employee Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: ( ) _____ Email: _____

Date of Birth: _____ Date of Hire: _____

3. Flexible Spending Account(s) Annual Election Information

☐ Health Care Flexible Spending Account ("**HCFSA**") (Maximum $2,600)

($_____per pay period) x (_____ # of deductions) = $ _____Your Annual Election

☐ Dependent Care Flexible Spending Account ("**DCFSA**") (maximum $5,000 by law)

($_____per pay period) x (_____ # of deductions) = $ _____Your Annual Election

4. Dependent Information

If electing health care and/or dependent care flexible spending account, list each *qualifying child* and/or *qualifying relative* for health care and/or dependent care flexible spending account expenses.

DEPENDENT NAME (First Name/Last Name)	DEPENDENT SOCIAL SECURITY NO.	DEPENDENT GENDER	RELATIONSHIP TO EMPLOYEE	DEPENDNET DATE OF BIRTH

5. Premium Expense Benefits

As an employee, you may participate in the premium expense benefit programs in the list below. Before you can participate, you must complete the appropriate enrollment form(s) for each of the benefits elected**. If you enroll in any of the premium expense benefit programs, then your premiums will automatically be deducted on a pre-tax basis each pay period unless you notify the employer of such decision to pay for the benefits on an after-tax basis.** Payroll deductions on an after-tax basis will result in payment of higher Social Security and federal unemployment taxes than if you participate on a pre-tax basis. Once elected, you cannot change your election for these premium expense benefit programs until the next open enrollment period or until a qualifying event occurs. *Complete the table below by writing the amount of your deduction(s) in the appropriate pre-tax or after-tax column below.*

BENEFIT	PER PAYCHECK PRE-TAX DEDUCTION	PER PAYCHECK AFTER-TAX DEDUCTION
MEDICAL	$	
DENTAL	$	
EMPLOYEE LIFE	NA	$
DEPENDENT LIFE	NA	$
SHORT TERM DISABILITY	NA	$
ACCIDENT INSURANCE	$	
CANCER INSURANCE	$	
CRITICAL CARE INSURANCE	$	
HOSPITAL INDEMNITY INSURANCE	$	
SPECIFIED EVENT INSURANCE	$	

6. Acknowledgment and Authorization of Withholdings

I acknowledge that I have been given the opportunity to enroll in the premium expense benefit plans, HCFSA and DCFSA. On a separate benefit enrollment form(s), I have enrolled for the premium expense plans for which I am eligible for coverage. I authorize my employer to reduce my pay each pay period and deposit into my employee plan account(s), in equal deposits, the amount necessary to satisfy the benefits I have elected on this agreement according to the rules applying thereto. I acknowledge that my actual take-home pay may be higher or lower depending on the coverage I select. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. If I chose premium expense benefits on an after-tax basis instead of a pre-tax basis, I understand that my Social Security and federal unemployment deductions may be higher than if I chose to pay them on a pre-tax basis.
I understand that:

I cannot change or revoke any of my elections on this salary redirection agreement at any time during the Plan Year unless I experience a qualifying event, and my election is consistent with such event change. HCFSA 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 Plan Year. Prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my premium expense benefits then in effect for the new Plan Year but **not** my HCFSA or DCFSA benefits. HCFSA and DCFSA elections must be made each Plan Year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the premium expense benefit option.

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.

Employee Signature: X_____ **Date:** _____

Employee Print Name: _____ **BMI Group No.:** BMI179_____

The elections on this *Salary Redirection Agreement* are accepted and agreed to by the Employer's Authorized Representative

Payroll Schedule: ☐ Weekly ☐ Bi-weekly ☒ Monthly ☐ Semi-monthly

First Payroll Deduction Begins: _____

Employer Signature: X_____ **Date:** _____

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