

**EMPLOYER CAFETERIA PLAN  
SALARY REDIRECTION/REDUCTION AGREEMENT**

EMPLOYER: Kern Community College District

EMPLOYER'S TAX ID NUMBER: 95 - 6006644

AFFILIATE'S NAME/LOCATION: \_\_\_\_\_

AFFILIATE'S TAX ID NUMBER: \_\_\_\_\_ - \_\_\_\_\_

CAFETERIA PLAN YEAR   /  /   -   /  /  

(CHECK ONE)  OPEN ENROLLMENT OR  NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE:   /  /  

SOCIAL SECURITY NO: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMAIL: \_\_\_\_\_

No. of Payroll Cycles in Plan Year: 12 Date of First Distribution 10/1/17 Payroll Mode Weekly Biweekly Semimonthly Monthly

On a separate benefit enrollment form(s), I have enrolled for a certain benefit or insurance coverage(s) and understand that my required contribution will be deducted from my paycheck by my employer or a third-party payroll administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to employer-provided, nonelective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Cafeteria Plan as elected in the Pre-Tax Colum below. Any previous election and Salary Redirection Agreement under the Cafeteria Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/ contribution amounts hereunder shall evidence acceptance of this agreement.

**Check the desired coverage(s) below.** (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for an increase/decrease in premium or required contribution) except as indicate below.)

	<u>Pre-Tax</u>	<u>After-Tax</u>		<u>Pre-Tax</u>	<u>After-Tax</u>
Medical Coverage	<input checked="" type="checkbox"/>	_____	Specified Health Event Insurance	_____	_____
Dental Insurance	_____	_____	Short-Term Disability Insurance	_____	_____
Vision Insurance	_____	_____	Long-Term Disability Insurance	_____	_____
Cancer Insurance	_____	_____	Hospital Confinement Indemnity Insurance	_____	_____
Hospital Intensive Care Insurance	_____	_____	Personal Sickness Indemnity Insurance	_____	_____
Accident Insurance	_____	_____	Health Savings Account (HAS) 223	_____	_____
Group Term Life Insurance (if family, must be after-tax)	_____	_____	Other accident or health plan(s) under Section 106 of the Internal Revenue Service Code	_____	_____
			List: _____		

**Required acknowledgment to participate in Cafeteria Plan:**

I certify that the features and benefits under the Cafeteria Plan have been explained to me completely. By initialing, I acknowledge that I understand the important information regarding participation in the Cafeteria Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Cafeteria Plan.

**INITIAL**

**WAIVER OF PRE-TAX BENEFITS UNDER THE CAFETERIA PLAN:**

I elect to waive all pre-tax benefits under the Cafeteria Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

**INITIAL**

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_