MONROE TOWNSHIP SCHOOLS
423 Buckelew Ave.
Monroe Township, NJ 08831
Health Benefits
732-521-1500 x 5213

A cafeteria plan is a type of employee benefit plan that allows employees to choose between different types of benefits, similar to the choice of items in a cafeteria. Qualified cafeteria plans are excluded from gross income.

The district offers a **Premium Only Plan(POP)** that allows you to pay for qualified benefit insurance premiums before any taxes are deducted from your paycheck. In addition, there are two **Flexible Spending Accounts or FSA's.**

An **FSA**, allows an employee to set aside a portion of earnings to pay for qualified expenses such as medical and/or dependent care costs. The money deducted from an employee's pay into a FSA is not subject to payroll taxes, resulting in a tax savings. *One disadvantage is that funds not used by the end of the plan year are lost to the employee and forfeited back for administrative costs.*

A medical FSA can be used to pay for expenses not paid for by insurance, usually deductibles, copayments, coinsurance amounts and allowable over-the-counter items. The medical FSA amount is $2,500 per year. Employees can elect any amount up to and including this amount.

A dependent care FSA can be used for certain expenses to care for dependents that live with you while you are at work. This can include children under thirteen, children of any age who are physically or mentally incapable of self-care, and senior citizens who live with you. The dependent care FSA amount is $5,000 per year per family. Employees can elect any amount up to and including this amount.

If you are interested in any or all of these plans, please complete the attached enrollment form and return it to Nichol Leischker, Benefits Coordinator in Central Office. The plan is based on the calendar year and will run from January through December. We will be using a debit card system implemented and overseen by Discovery Benefits. More information (guides and a video link) can be found on the district website under **HR/Health Benefits/S125 Plan Info.**

SECTION 125
PREMIUM ONLY PLAN
SALARY REDUCTION AGREEMENT

PERSONAL INFORMATION

Last Name	First Name	Middle Initial	Social Security Number
Home Address Street	City	State	Zip
Date of Birth: / / Sex: ☐ Male ☐Female	Marital Status: ☐Single ☐Married	Date of Hire: / /	

AGREEMENT

I have read and understand the explanation I have received regarding the benefit option(s) available to me under the Monroe Township School District's Section 125 Plan. I understand that I have the right to allow the School District to reduce my compensation on a pretax basis during the plan year (or the part of it that remains) and to apply this reduced amount toward the cost of the Option(s) that I have elected. I further understand that if the cost of my elected option(s) changes from time to time, my share of the cost, and the amount by which my compensation is reduced, may be automatically adjusted accordingly.

I acknowledge that this agreement is irrevocable unless there is a change in status. A change in status includes, but is not limited to, the following events: marriage; divorce or legal separation; death of a spouse or dependent; birth or adoption of a child; a change in the number of my dependents; a termination or commencement of employment; a strike or lockout; commencement of or return from an unpaid leave of absence; a change of worksite; a change in my or my spouse's employment status that affects eligibility for dependent participation in this or another cafeteria plan; a change in my residence or in the residence of my spouse or dependents; or my dependent either satisfying or ceasing to satisfy eligibility requirements for a coverage due to attainment of age, a change in student status or similar circumstances.

By signing below, I hereby authorize the School District to adjust my compensation based on the benefit option(s) that I have elected. I further understand that the benefit option(s) that I have elected and this Agreement will remain in force throughout the plan year (or the part of it that remains), unless there is a change in status, as described above.

_____ _____

Employee Signature Date

_____ _____

School District Representative Date

Discovery Benefits
FSA • HSA • HRA • COBRA • Transportation

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Flexible Spending Account Enrollment Form

*= Required Fields

Step 1: Participant Information

*Employer Name (Do not abbreviate)

*Employee ID Number

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Mailing Address

Email Address (If provided, all notifications will be sent via email)

*City

*State *Zip

Day Telephone

*Birth Date (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

***Enrollment Reason** (Please circle one): Open Enrollment Period / New Hire

Gender (Please circle one): Male/Female

Marital Status (Please circle one): Married/Single

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. *Please Note: Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

	Medical FSA Limit set by employer	**Dependent Care Account** Limit set by employer up to IRS maximum	**Limited FSA** Limit set by employer if this plan type is offered
***Plan Type** (if enrolled in an HSA, you are not eligible to enroll in the Medical FSA. However, you are eligible for both the Limited Medical FSA and Dependent Care FSA if offered through your employer)			
***Annual Election** (if employer funded, note 'ER' next to amount)	$		
***Number of Pay Periods** (if enrolling mid-year, please enter the number of remaining pay periods within the plan year)	÷		
***Per Pay Period Amount** (to be deducted each pay period)	=		
***Date of First Payroll** (mm/dd/yyyy)			
***Participant Effective Date** (mm/dd/yyyy)			
***Pay Frequency** (please circle one)	Monthly / Semi-Monthly / Bi-Weekly (24) / Weekly / Other		

Step 4: Optional Services

*Please select only one. Check with your employer as to which services your plan offers.

	Debit Card	A debit card pays directly from your Flexible Spending Account at the point-of-sale. Itemized receipts are required for all transactions that are not auto-substantiated at the point-of-sale.
	Auto EOB	Auto EOB is the automatic crossover of eligible health claims from a participant's health insurance carrier. Payment is made automatically to you from your Flexible Spending Account.

Step 5: Authorization or Refusal

*Please select only one.

Participant Authorization
I authorize my employer to reduce my pay on a per pay period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

Participant Refusal
I do not want to participate. I understand that by refusing to participate, I will be unable to enroll this plan year unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit the change within a reasonable amount of time as deemed by the IRS and my employer.

*Employer Signature (Not required during open enrollment)

*Date

*Participant Signature

*Date

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