Employee Flexible Benefit Plan
Employee Election Form
Annual Enrollment

Employer's Name: **North Fork Local School District**

Employee's Name: _____ Social Security Number: _____

The employer and I agree that my compensation will be reduced by the amount required to pay my portion of the benefit(s) elected below for each pay period during the plan year and each subsequent plan year.

Election of Benefits (***initial*** *the applicable line*):

_____ I have enrolled for coverage under one or more of the following insurance plans on the appropriate forms: **HEALTH MAINTENANCE , DENTAL, AND/OR VISION** . I elect coverage under the Employee Flexible Benefit Plan.

_____ I **DECLINE** coverage under the Employee Flexible Benefit Plan.

I understand that:

- If my required contributions for my benefits are increased while this election remains in effect, my compensation reduction will automatically be adjusted to reflect that increase.
- During the open enrollment period, I will be offered the opportunity to change my benefit election for the upcoming 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 benefit coverage then in effect for the new plan year.
- I cannot change or revoke this election at any time during the plan year unless I have a change in family status. A change in family status includes the birth or adoption of a child, marriage, divorce, death, spouse's termination or commencement of employment, or such other events as the Plan Administrator determines will permit a change of an election.
- In certain limited circumstances (involving significant changes in the underlying insurance contracts or prepaid health contracts) I may be permitted to revoke or change my election.

This election is subject to the terms of the employer's Employee Flexible Benefit Plan as amended from time-to-time.

_____ _____

Employee's Signature *Date*

Accepted by the Employer:

_____ _____

HR/Benefit's Signature *Date*