

**East Georgia College**  
**SECTION 125 FLEXIBLE SPENDING ACCOUNTS PROGRAM**  
**SALARY REDUCTION AGREEMENT**

<b>NAME:</b>	<b>SSN:</b>
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On separate benefit enrollment form(s), I have enrolled for certain insurance coverage and understand that an amount equal to the total amount of premiums for coverage(s) elected less any Non-elective Contribution allocable thereto will be withheld from my salary. I elect to receive (check coverage(s) desired):

	<b>PRE-TAX</b>	<b>PRE-TAX</b>
Health Flexible Spending Account	\$ _____ per month	\$ _____ per year
Dependent Care Flex Spending Acct.	\$ _____ per month	\$ _____ per year

under the Flexible Spending Account Program as elected in the Pre-tax column. Any previous election and Salary Reduction Agreement under the Flexible Spending Account Program relating to the same benefits as selected above is hereby revoked.

**WAIVER OF PRE-TAX BENEFITS UNDER  
THE FLEXIBLE SPENDING ACCOUNT PROGRAM**

{ } [Check box if applicable] I elect to waive all pre-tax benefits under the Flexible Spending Account Program. Except for a Change in Status, I understand that I cannot elect pre-tax benefits until the next Anniversary Date (January 1).

I have read and agree to the terms of participation set forth on page two (2) of this document.

**EMPLOYEE**

**ACCEPTED AND AGREED TO BY:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Plan Administrator/Employer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**DECLINATION**

I decline participation in the Flexible Spending Accounts Program at this time.

\_\_\_\_\_  
Employee Name (Please Print – Last, First, MI)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

I agree that my Compensation will be reduced by the amount on my required contribution for the Benefit Plan(s) or Policies I have elected under the Flexible Spending Account program, continuing for each pay period until this agreement is amended or terminated. The amount of my required contribution for each Benefit Plan or Policy selected is set forth on a schedule that has been provided to me. I understand that:

- I cannot change or revoke this Salary Reduction Agreement with respect to Pre-tax Premiums as of any date prior to the next Anniversary Date (January 1) unless a Change in Status occurs (i.e., marriage, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse and such other events as will permit a change or revocation of an election under the Internal Revenue Code, as amended) and the change is caused by and consistent with the Change in Status.
- Execution of this Salary Reduction Agreement does not initiate coverage under the component Benefit Plans or Policies. Coverage will be determined under the separate Benefit Plans or Policies.
- Pre-Tax Premiums paid pursuant to this Salary Reduction Agreement reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation which is considered for Social Security purposes.
- Amounts remaining in my Health and/or Dependent Care Flexible Spending Account (FSA) after the end of the Plan Year will be forfeited.
- Prior to the Anniversary Date each year (January 1), I will be offered the opportunity to add or drop coverage(s) 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 participation in the Plan on the same basis with the same coverage(s). Notwithstanding the foregoing, I understand that Health Dependent Care FSA elections must be made by affirmative election.
- I agree to notify my Employer if I have reason to believe that any expense(s) for which I have obtained reimbursement is not an Eligible Medical Expense, and also agree on demand to indemnify and reimburse my Employer for any liability it may incur for failure to withhold federal and state income tax or Social Security tax for any reimbursement I receive for an expense which does not qualify as an Eligible Medical expense, up to the amount of additional tax actually owed by me. I hereby release any claims for wrongful disclosure of information based upon the administrator's use or disclosure of the health information herein, so long as such information is used in furtherance of the administration of the Plan.

\_\_\_\_\_ Employee's Initials