Sudbury Extended Day, Inc. (SED)
2019-20 Employee Pre Tax Benefit Plan Enrollment Form

Name _____Social Security Number _____

Section I - Pre-Tax Health Insurance Premium Payment

I understand that payment of any contributions required from me for any coverage I have elected under SED's health plans will be on a pre-tax basis in accordance with the provisions of SED's Pre Tax Benefit Plan.

All premiums based on 21 paychecks.

- ☐ I decline Health Insurance
- ☐ Individual premium, employee portion **$109.72/paycheck**
- ☐ Couple premium, employee portion **$219.45/paycheck**
- ☐ Single Parent with Dependent, employee portion **$202.99/paycheck**
- ☐ Family premium, employee portion **$312.72/paycheck**

Section II - Pre-Tax Dental Insurance Premium Payment

I understand that payment of any contributions required from me for any coverage I have elected under SED's dental plans will be on a pre-tax basis in accordance with the provisions of SED's Pre Tax Benefit Plan.

All premiums based on 21 paychecks.

- ☐ I decline Dental Insurance
- ☐ Individual premium, employee portion **$28.34/paycheck**
- ☐ Couple premium, employee portion **$48.69/paycheck**
- ☐ Family premium, employee portion **$70.85/paycheck**

Section III – Medical Flexible Spending Account

I elect to have the amount that I have indicated below credited to a Medical Flexible Spending Account for me. I understand that my pay will be reduced by the amount I have elected in accordance with the provisions of SED's Pre Tax Benefit Plan. The annual amount elected will be divided among 21 pay periods.

Annual amount $ _____ (**Not to exceed $2650**)

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Section IV – Dependent Care Flexible Spending Account

I elect to have the amount that I have indicated below credited to a Dependent Care Flexible Spending Account for me. I understand my pay will be reduced by the amount I have elected in accordance with the provisions of SED's Pre Tax Benefit Plan. I understand that the maximum amount which can be credited for the year is the least of (a) $5,000 ($2,500 if I am married and I file a separate federal income tax return) and (b) My earned income for the year (after reduction for dependent care assistance), or (c) my spouse's actual or deemed earned income. The annual amount elected will be divided among 21 pay periods.

Annual amount $ _____(**Not to exceed $5,000 or such lesser limit as may apply above)**

Section V Enrollment Agreement

I understand that the elections under the Plan can be changed only at each annual enrollment, or as the result of a qualifying event.

Prior to each plan year (the "new year"), I will be offered the opportunity to make elections under the Plan for the new plan year. If I do not make elections at that time, I will be treated as having agreed (a) to continue any health coverage in effect under the Plan immediately before the new year (to the extent such coverage remains available under the Plan for the new year) and (b) to pay any required contributions for such coverage through a reduction in salary equal to the amount of any required contributions. If I do not make a new election with respect to the Medical Flexible Spending Account or Dependent Care Flexible Spending Account, I will not have any amounts credited to those accounts for the new plan year.

I understand that any unused amount remaining in the Medical Flexible Spending Account or Dependent Care Flexible Spending Account three months after the end of the plan year (November) will be forfeited and will remain the property of SED. I understand that by providing individuals with the opportunity to elect coverage under a health insurance plan, SED does not assume liability for any medical expense of any nature.

SED, as Administrator of the Plan, may modify or terminate this Agreement to the extent it deems necessary to comply with applicable law.

Signature _____ Date _____