EMPLOYER CAFETERIA PLAN
SALARY REDIRECTION/REDUCTION AGREEMENT

EMPLOYER: Cambria Community Services District

EMPLOYER'S TAX ID NUMBER: 95 - 3082560821

AFFILIATE'S NAME/LOCATION: _____

AFFILIATE'S TAX ID NUMBER: _____ - _____

CAFETERIA PLAN YEAR: 01/01/24 - 12/31/24

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

SOCIAL SECURITY NO.: _____ DATE OF BIRTH: ___/___/___ PHONE: (___) N/A

NAME: (Last) _____ (First) _____ (Middle Initial) _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: N/A

No. of Payroll Cycles in Plan Year: 26 Date of First Deduction: ___/___/___ Payroll Mode: ☐ Weekly ☑ Biweekly ☐ Semimonthly ☐ Monthly

On a separate benefit enrollment form(s), I have enrolled for 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 column 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 any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage			Specified Health Event Insurance	N/A	N/A
Dental Insurance			Short-Term Disability Insurance		
Vision Insurance			Long-Term Disability Insurance		
Cancer Insurance	N/A	N/A	Hospital Confinement Indemnity Insurance		
Hospital Intensive Care Insurance			Personal Sickness Indemnity Insurance		
Accident Insurance			Health Savings Account (HSA) §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:** _____