WOONSOCKET EDUCATION DEPARTMENT PREMIUM ONLY PLAN

ELECTION FORM AND SALARY REDUCTION AGREEMENT

September 1, 2023 TO August 31, 2024

Employee Name: _____

Employee Social Security Number: _____

I acknowledge that I have received the Summary Plan Description for the above-referenced Plan. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan. I understand that my decision regarding coverage is effective through August 31, 2024.

In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected for the plan year specified above. The Employer and I agree that my cash salary will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

ELECTION OF INSURED BENEFITS

1. On the appropriate benefit enrollment form(s), I have enrolled for certain insurance coverage(s).

a.___I have no required contribution for coverage at this time.

b.___I elect to pay my required contributions for the following coverage(s) on a **pre-tax** basis under the Plan:

Coverage

_____group medical insurance
_____group dental insurance

(if you select only one coverage, please complete items b or c below, as applicable)

(X) In lieu of specifying a dollar amount per pay period, I hereby elect the above insurance coverage's and authorize the Employer to reduce my salary by the amount of current premiums required on my behalf for participation in the coverage selected. I understand that if my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my salary reduction will automatically be adjusted to reflect that increase or decrease.

c.___I elect to pay my required contributions for the group insurance coverage(s) not selected above on an **after-tax** basis.

d.___I elect <u>not</u> to participate in the Plan with respect to the coverage(s) not selected above. (Proof of coverage under another medical and/or dental plan may be required by the Employer.)

OTHER TERMS AND CONDITIONS

- I cannot change or revoke any of my elections or this salary reduction agreement at any time during the plan year unless I have a change in status and I notify the Employer of this change in writing.

- The Plan Administrator may reduce or cancel my salary reduction or otherwise modify this agreement in the event it believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

- The reduction in my cash salary under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by the Employer.

- Prior to the first day of each plan year, I will be offered the opportunity to change my benefit elections for the following plan year. ***If I do not complete and return a new election form by the deadline specified by the Employer, I will be treated as having elected the same benefit option(s) I had for the previous plan year.***

Signature: _____ Date _____

Print Name:_____