

Southern Lehigh School District

SECTION 125 PLAN ELECTION FORM FOR THE 2025 PLAN YEAR

This election form is for the Plan Year beginning January 1, 2025, ending December 31, 2025

Employee Information:

Name: (First) (MI) (Last)	Last Four Numbers of Social Security No: XXX – XX – ____
Address: (Street) (City) (State) (Zip)	

Part One: Insurance Contributions

The first part of your Section 125 Plan involves the insurance premiums you currently pay through your employer via payroll deduction. These premiums can be for Health, Dental, Vision, or any other Insurance Plans deemed eligible by the Internal Revenue Service that your employer offers. These Plans must be sponsored by your employer to be eligible for the pre-tax benefit through your Section 125 Plan. Individually owned policies or policies sponsored by your spouse's employer are **not** eligible through this Plan. Please indicate your election by checking the appropriate box below:

Please check one:

[]	Yes, I want to save taxes! Please deduct the portion I pay towards my insurance before applicable taxes are calculated on my income!
[]	No, I do not wish to save taxes on this expense. Please deduct my insurance contribution after applicable taxes are calculated on my income.
[]	I elect to opt out of the Medical Insurance Program. I understand by making this election I will not receive any Medical Benefits. Please add \$75.00 to my monthly taxable income in lieu of Medical Benefits (only FT eligible employees receive cash in lieu of the benefit). You must attach a photocopy of the health insurance card by which you will be covered. FT Employee _____ PT Employee _____
[]	My position does not qualify for District medical benefits. This section does not apply to me.

Part Two: Flexible Spending Accounts (FSA):

The second part of your Section 125 Plan consists of the Health Care Reimbursement (FSA) and Dependent Day Care Reimbursement. If you choose to enroll in one or both of these accounts, please make your election below. Your election should not exceed the plan maximums.

FLEXIBLE SPENDING ACCOUNT	PRE-TAX AMOUNT PLAN YEAR	PRE-TAX AMOUNT PER PAY	PLAN YEAR MAXIMUMS
Health Care Reimbursement (UNINSURED MEDICAL, DENTAL, & VISION EXPENSES) * Please see Special Notes on the reverse side of this form	\$	\$	\$3,300
Dependent Day Care* * Please see Special Notes on the reverse side of this form	\$	\$	\$5,000 if single or married filing jointly; \$2500 if married filing separately

Waiver of FSA Coverage (please check):

[]	I do not wish to participate in a Flexible Spending Account.
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I acknowledge that:

I have voluntarily elected to participate in the Plan for the benefits listed above and hereby authorize my employer to reduce my salary for the amount(s) shown above. I understand:

- Expenses must be consistent with allowable medical deductions under the IRS Publication 969
- Current participants must re-enroll each plan year.
- Funds will be forfeited if eligible expenses are not submitted for reimbursement by Plan year deadline or purchased utilizing the provided debit card.
- I understand that these plan elections do not constitute any enrollment of insurance coverage.
- If terminated, expenses may be incurred 30 days after term date. Employee has 75 days to submit claims.
- I understand that I may not change elections during the plan year, unless there is a change in my family status. I understand that I have 30 days from the date of the occurrence to make changes to my plan.
- I agree to notify the plan administrator within 30 days should I no longer meet Dependent Care eligibility as mandated by the IRS.

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Employee Signature	<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Date
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The following is a list of the qualifying events that would enable you to change a prior election in the current plan year.

- ❖ Change in legal marital status. (marriage, divorce, legal separation/annulment)
- ❖ Change in your number of tax dependents (i.e. Birth or Adoption of a child).
- ❖ Death of a spouse or child.
- ❖ Job status change of myself/spouse/dependent. (full/part-time, termination/beginning of employment)
- ❖ Change in my spouse/dependents insurance coverage, a significant change in premiums, dependent no longer eligible for insurance coverage.

- ❖ For Dependent Care Only – A change of Care Providers, Number of days and/or Cost changes.

Special Notes:

1. 24 pays are used to calculate amount per pay for Flexible Spending Accounts for Professional staff and all 12-month employees. Non-professional staff working 10-months per year will have their annual election divided over 17 pay periods.
2. Dependent Day Care generally can not be used if one parent remains at home to care for the child.

If you have any questions regarding the Section 125 Plan, please feel free to contact Deneen Carreras at extension 5202.