BOCES Southern Westchester

THE BOARD OF COOPERATIVE EDUCATIONAL SERVICES

Tax ID Number 13-6007351

AFLAC SALARY REDIRECTION AGREEMENT – PLAN YEAR 1/1/10 – 12/31/10

NAME: _____
Last **First** **Middle Initial**

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____ **ELIGIBILITY DATE:** _____

NUMBER OF PAYROLL CYCLES IN PLAN YEAR: 20 **DATE OF FIRST DEDUCTION:** 1/15/2010 **PAYROLL MODE:** Bi-Weekly

On a separate benefit enrollment form(s), I have enrolled for certain insurance coverage(s) and understand that my required contribution and/or Flexible Savings Account(s) (FSA) election amounts will be deducted from my paycheck by my employer or Third Party Payroll Administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an equal amount equal to my required contribution for my elected coverage and/or FSA account election amount 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" non-elective 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 Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits 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.

MEDICAL COVERAGE

PRE-TAX	AFTER-TAX

COMPLETE THE FOLLOWING ELECTIONS ONLY IF PARTICIPATING IN A MEDICAL OR DEPENDENT CARE FSA PLAN:

FSA PLAN ELECTION	PER PAY PERIOD AMOUNT	NUMBER OF DEDUCTIONS	ANNUAL ELECTION AMOUNT
MEDICAL FSA PLAN			
DEPENDENT CARE FSA PLAN			

REQUIRED ACKNOWLEDGEMENT TO PARTICIPATE IN FLEXIBLE BENEFITS PLANS:

INITIAL	
	I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Flexible Benefits Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Flexible Benefits Plan.

WAIVER OF PRE-TAX PREMIUMS UNDER THE FLEXIBLE BENEFITS PLAN:

INITIAL	
	I elect to waive all pre-tax benefits under the Flexible Benefits Plan. Except for 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.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

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