Reset Form

LOCAL 434 CAFETERIA PLAN
(Dental and Vision Benefits)
Election Form/Compensation Reduction Agreement

Employee Name:_____

Social Security No.:_____

Address:_____

_____

Street City State Zip Code

I certify that I have received materials describing the Local 434 Health and Welfare Fund's (the "Fund") optional dental and vision benefits and understand that receipt of these optional benefits is voluntary. I understand that I can pay for these benefits with pre-tax dollars through the Local 434 Cafeteria Plan (the "Plan") or I can pay for these benefits with funds I have accumulated in my Dollar Bank, while I remain eligible to participate in the Plan.

Election of Pre-Tax Benefits

By signing and returning this Agreement to the Fund, I elect to receive dental and vision benefits under the Plan. Please check one of the following options for payment of these dental and vision benefits:

Option 1

☐ I authorize my employer to deduct from my pay each pay period $0.79 per hour, on a pre-tax basis, for every hour that I work. I understand that any excess deductions will be applied to my share of premium costs for major medical benefits under the Fund for the next following month. I understand that I will receive a self-pay invoice if insufficient deductions are forwarded.

Option 2

☐ I authorize the Administrative Office to deduct $106.00 from my Dollar Bank each month.

I understand that I cannot elect to participate in the Plan until the next open enrollment period if I do not timely return this Agreement.

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth adopted or placement for adoption.

Elections Irrevocable Unless Exception Applies

I understand that

- I cannot revoke this Agreement as of any date prior to the exhaustion of the Initial Enrollment Period. The Initial Enrollment Period includes the months in the calendar year following your initial enrollment and the next calendar year. Please contact the Fund's Administrative Office if you qualify for the Special Enrollment exception described above.
- The Agreement terminates when I become ineligible for participation in the Fund or the Plan.
- I will be notified if there is a change in the amount that will be deducted from my pay or from my Dollar Bank for Plan benefits. However, I understand that I will not be able to revoke my election based on a change in the amount of pay required for benefits except during an open enrollment period.
- My election will apply to all Fund Employers that I work with.

Additional Terms

I agree that my compensation will be reduced by the amount required for the dental and vision benefits that I have elected under the Plan, and that such deductions will continue until this Agreement is amended or terminated (Option 1 only). Also, I understand that:

- If I do not complete and return a new Agreement after the Initial Enrollment Period during an open enrollment period, then the elections selected on this Agreement will continue (Option 1 and Option 2).
- Deductions under this Agreement reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of Compensation that is considered for Social Security purposes (Option 1 only).

I have read and agree to the terms of participation set forth on this Agreement.

_____

Employee's Signature Date

Please return this Agreement to:

Local 434 Health and Welfare Fund
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

If you have any questions, please contact the Administrative Office at 1-800-535-6373.