KINGSTON
CITY SCHOOL DISTRICT
We Inspire. We Educate. We Graduate.
All Students. All of the Time

MEMO TO: **All Employees**

FROM: **Abbie Reinhardt, Coordinator of HR, Payroll, and Benefits**

DATE: **May 24, 2021**

RE: **2021-2022 Payroll Calendar & Information**

NOTE **- The last pay date for 2020/2021 is June 18, 2021. This is your final *contract* payment for the 20/21 school year & includes payment for services through June 30, 2021.**

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12 & 11 Month Employees:

The first pay date for 2021/2022 is Friday, July 2, 2021.

10 Month Employees:

The first pay date for 2021/2022 is Friday, September 10, 2021.

21 Pays - Regular Bi-weekly paychecks 9/10/21-6/17/22.

26 Pays - Regular Bi-weekly paychecks, PLUS 5 additional checks on 6/17/22.

Direct Deposit Employees:

All checks will be sent electronically to your bank.

Payroll Office:

Lisa Faxon
845-943-3026
lfaxon@kingstoncityschools.org

Ron Higgins
845-943-3027
rhiggins@kingstoncityschools.org

Payroll Schedule - 2021/2022

Timesheets/Payroll Claims Due in Payroll Office	Checks Distributed
June 21	July 2
July 6*	July 16
July 19	July 30
Aug 2	Aug 13
Aug 16	Aug 27
Aug 30	Sept 10
Sept 13	Sept 24
Sept 27	Oct 8
Oct 12*	Oct 22
Oct 25	Nov 5
Nov 8	Nov 19
Nov 22	Dec 3
Dec 6	Dec 17
Dec 17*	Dec 31
Jan 3	Jan 14
Jan 18*	Jan 28
Jan 31	Feb 11
Feb 14	Feb 25
Feb 28	Mar 11
Mar 14	Mar 25
Mar 28	Apr 8
Apr 8*	Apr 22
Apr 25	May 6
May 9	May 20
May 23	June 3
June 6	June 17**
June 21*	

Substitutes, Adult Education, Home Teachers, Hourly, and Per Diem employees will be paid on the above payroll dates. However, the amount paid will be for the previous bi-weekly period.

*** NOTE: Special Due Dates; Special Pay Dates**

****Checks issued on June 17, 2022 will complete contract payments for services through June 30, 2022.**

Salary Information for 2021-2022

Teaching salaries for the school year are based on 1/10th of the yearly contract salary per month for each full month of service. A teacher who provides service for one-half or less of the working days in any month, is to receive 1/200th if the annual salary for each day worked. A teacher who works more than one-half of the required working days, in any month, is to have a deduction of 1/200th for each day of unauthorized absence.

METHOD OF DISTRIBUTION:

Once started, the chosen plan must continue for the entire year. No exceptions

10 Month Employees:

Plan A: 21 paychecks - Annual salary divided into 21 equal payments Sept-June. (form attached)
Plan B: 26 paychecks - Annual salary divided into 26 equal payments Sept-June. PLUS five additional checks on the last payroll in June. (form attached)

Forms are due in the Payroll Office **by August 6, 2021**. Do not file a new form if there is no change from 2020/2021.

11 & 12 Month Employees:

No option. Annual salary divided into 26 equal payments July-June.

RETIREMENT MEMBERSHIP:

Mandatory – All full time Teachers, Teaching Assistants, and 12-Month Non-Professionals.

Optional – 10 month Non-Professional and Part Time employees.

Employees must submit an application to the appropriate retirement system if they are not already a member.

Individuals whose membership is optional must either submit an application for membership or sign a statement of declination at the time of their employment with the District.

SOCIAL SECURITY AND MEDICARE:

Since 1957, ten-month employees, substitute teachers, and non-professional substitutes that did not choose to join a retirement system could not have Social Security deducted from their paycheck. On November 5, 1990, President Bush signed the Omnibus Budget Reconciliation Act of 1990, which changed public employee Social Security coverage and established a new wage bracket for Medicare taxation. As of July 2, 1991, **ALL** employees are required to pay full Social Security and Medicare Taxes (6.2% Social Security and 1.45% Medicare), total 7.65%. The maximum wage subject to Social Security tax for 2020 is $142,800. However, those employees that reach this maximum will be required to continue to pay the Medicare portion on all salary earned.

CREDIT UNION DEDUCTIONS – OPTIONAL:

Ulster Federal Credit Union deductions may be withheld from your salary if you so choose. Those who desire Credit Union deductions, or more information, should contact the Ulster Federal Credit Union at 127 Schwenk Drive, Kingston (845-331-5544).

Employees with current Ulster Credit Union deductions will continue until Payroll is notified by Ulster Credit Union. Ulster Credit Union Deductions are withheld from every check.

AGENCY FEE DEDUCTIONS:

All members of the Administrative Supervisory Personnel Association (ASPA), the Kingston Teachers Federation (KTF), the Educational Support Personnel Association (ESP), and the Civil Service Employees Association (CSEA) will have the agency fee deducted from their payroll checks, if an authorization from the employee is received.

ELECTRONIC DEPOSIT OF PAYROLL CHECKS (Direct Deposit) – OPTIONAL:

Employees interested in having their payroll check electronically sent to a bank of their choice must complete the attached form for Direct Deposit and return it to the Payroll Office. If you presently have this option, it will remain in effect for 2021-2022.

TAX SHELTERED ANNUITY – OPTIONAL:

Arrangements can be made for Tax Sheltered Annuity deductions through several participating companies. The OMNI Group administers our 403(b) plan. You can contact OMNI at (877)544-6664 or email www.omni403b.com. An OMNI form is attached for reference.

HEALTH, DENTAL, AND OPTICAL INSURANCE:

Eligible employees of KTF and ESP wishing to enroll in MagnaCare with the Kingston Trust Fund must contact **Kathy Hyatt at (845)338-5422**.

Other eligible unit members enrolling in health, dental, or optical benefits should contact **Amanda Wells in the Business Office at (845)943-3029.**

FLEXIBLE SPENDING PLAN (FSA) - Benetech:

Available to all contractual employees of the Kingston City School District, this is reimbursement of heath care and/or dependent care. You may set up a pre-tax payroll deduction for reimbursement for medical (*annual maximum $2750*) and/or child care (*annual maximum $5000*), not covered by your insurance. The Kingston School District provider is Benetech. Information is attached. **Forms must be in the Payroll Office by June 30, 2021 – no exceptions!** All employees, including those who currently have Benetech, are **required to complete a new form each year.**

Kingston City School District

21 Pay Schedule

(Plan A)

I, _____ (print name), request that my salary for the 2021-2022 school year be divided as follows:

Plan A – Twenty-one (21) equal payments, distributed every other Friday, according to the pay schedule.

Signature: _____

Date: ____/_____/_____

School assigned: _____

Kingston City School District

26 Pay Schedule

(Plan B)

ELECTION TO DEFER SCHOOL DISTRICT COMPENSATION

FOR COMPLIANCE WITH U.S. TREASURY REGULATION

SECTION 1.409a-2 (A)(14)

(This election is effective 9/1/2021 and supersedes any prior election statement)

The election statement below is intended to meet the requirements of US Treasury Regulation Section 1.409a-2(A)(14). If a school employee wishes to receive their salary spread over a 12 month period (26 pays September-June) versus receiving all total compensation during the regular school year (21 pays September-June), this election form must be completed. The election must be made before the beginning of the school year to which it applies.

DEFERRED PAYROLL ELECTION

I, _____(print name), elect to receive my school year compensation spread over a twelve month period instead of only during the school year. I understand that my compensation will be divided by 26, with 21 pays occurring on a bi-weekly basis from Sept-June, and the remaining 5 pays occurring on the last pay date before June 30th.

My election is effective the first day of September 2021, for the entire 2021-2022 school year and thereafter, until I revoke this election for a subsequent school year.

I understand my election is irrevocable once the school year begins.

Signature: _____

Date: ____/____/____

School assigned: _____

KINGSTON
CITY SCHOOL DISTRICT
We Inspire. We Educate. We Graduate.
All Students. All of the Time.

Memo

To: Employee

From: Payroll Office

RE: Direct Deposit

If you wish to have your payroll check electronically deposited, please complete the attached form. In order to ensure accuracy, a voided check or document from your bank must be included.

The paycheck following submission of this form will be a "pre-note" where account information is verified with the bank and no actual money is sent (you will be issued a "real" check). This step is necessary to guarantee there are no software errors. The following check will be electronically deposited and your check stub will be sent to you.

If you have any questions or concerns, please contact the Payroll office.

KINGSTON CITY SCHOOL DISTRICT

21 WYNKOOP PLACE

KINGSTON, NY 12401

Direct Deposit

I hereby authorize Kingston City School District, hereinafter called COMPANY; to initiate debit entries to my account (**CAN ONLY SELECT ONE AT THIS TIME**):

Checking Account _____ (MUST ATTACH VOIDED CHECK **OR** PAPERWORK FROM YOUR BANK)

Savings Account _____ (MUST ATTACH DEPOSIT SLIP)

Indicated below at the depository financial institute named below, hereinafter called DEPOSITORY, and to debit the same to each account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of US law.

Depository (Bank) Name:_____ Branch:_____

City:_____ State:_____ Zip Code:_____

Routing Number:_____ Account Number:_____

This authorization is to remain in full force and effect until COMPANY has received written notification from me of its termination in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name:_____ SS#:_____

Date:_____Signature:_____

Note: Debit authorizations must be provided so that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

403(b) SALARY REDUCTION AGREEMENT FORM (SRA) For Tax Sheltered Annuities and Custodial Accounts

- Please supply the information requested below.
- Read all agreements on this form before submitting.
- Fields having an asterisk notation are required.

403(b)

IMPORTANT NOTICE: Before You Sign, Read All Information on this form:
A Tax Sheltered Annuity ("TSA") is an investment account that is set aside for your retirement (only), and is paid for with "pre-tax" dollars. A Custodial Account ("CA") is the group or individual custodial account or accounts, established for each Employee, by the Employer, or by each Employee individually, to hold assets of the Plan. Unless utilizing the catch-up provisions, your Maximum Allowable Contribution ("MAC") cannot exceed $19,500 ($26,000 if age 50 or over) in 2021. Both TSA & CA receive tax deferred treatment.

Part 1: Employee Information

☐ Check here if you have contributed to another 403(b), 401(a), or 401(k) plan offered by another employer in the current calendar year. **NOTE: Do not check this box if you have only contributed to the 403(b) plan associated with this SRA.** If so, please provide the amount of the year-to-date contributions you have made to the other plan(s): $[ ] and, if applicable, the name of the other Plan: [ ]

* Social Security Number: [ ] * First Name: [ ] MI: [ ] * Last Name: [ ]

*Address: [ ]

* City: [ ] *State: [ ] *Zip: [ ]

* Date of Birth: [ ] * Phone: [ ] *Email address: [ ]

Part 2: Employer Information

* Full Organization Name, City and State: [ ] * Date of Hire: (mm/dd/yyyy) [ ]

Part 3: Contribution Information

OPTION 1: Recurring Contributions

WARNING!!! Any new recurring contributions will supercede all current recurring contributions to your employer's 403(b) plan administered by OMNI. If you are currently contributing to multiple service providers under your employer's 403(b) plan, please be sure to list all contributions you wish to continue. Any active 403(b) contributions found in our records, but not listed below WILL BE DISCONTINUED.

Also, a contribution may be discontinued by listing it below with an amount of zero.

Please withhold funds from my pay for the following 403(b) contributions until further notice:

Plan Type	Service Provider	Account #	Effective Date	Amount Per Pay
☐ 403(b) ☐ ROTH 403(b)				
☐ 403(b) ☐ ROTH 403(b)				
☐ 403(b) ☐ ROTH 403(b)				
☐ 403(b) ☐ ROTH 403(b)				
☐ 403(b) ☐ ROTH 403(b)				

☐ Please check here if you are NOT a full-time employee

OPTION 2: One-Time Contributions (Elective Contributions Only)

Plan Type	Service Provider	Account #	Effective Date	Amount	After this contribution, any 403(b) recurring contributions to this service provider should be:
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED

☐ Please check here if you are NOT a full-time employee

OPTION 3: Participation Opt Out

☐ **I do not wish to participate at this time.** I understand that I may participate in the future simply by filling out a new Salary Reduction Agreement form.

Continued on next page...

Part 4: Agreements and Acknowledgements

The above named Employee where applicable, agrees as follows:

1. To modify his/her salary reduction as indicated above.
2. That his/her Employer transfers the above stated funds on Employee's behalf to OMNI for remittance to the selected Service Provider(s).
3. This SRA is legally binding and irrevocable with respect to amounts paid.
4. This SRA may be changed with respect to amounts not yet paid.
5. This SRA may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new SRA is submitted.
6. (a) That OMNI does not choose the annuity contract or custodial account in which your contributions are invested.
   (b) OMNI does not endorse any authorized Service Provider, nor is it responsible for any investments.
   (c) OMNI makes no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the TSA and/or CA described herein.
   (d) (i) OMNI shall not have any liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the TSA and/or CA, its terms, the selection of any service provider, the financial condition, operation of or benefits provided by said service provider, or his/her selection and purchase of shares by any service provider. Nothing herein shall affect the terms of employment between Employer and Employee.
   (ii) Employee acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account described herein.
   (iii) The Employer shall not have any liability for any and all losses suffered by an Employee with regard to the selection(s) of any TSA and/or CA, any related terms and conditions, the selection of any service provider, the financial condition, operation of or benefits provided by any service provider or the selection and purchase of shares by any service provider.
7. To be responsible for setting up and signing the legal documents necessary to establish a TSA or CA.
8. To be responsible for naming a death beneficiary under their TSA or CA. This is normally done at the time the contract or account is established. Beneficiary designations should be reviewed periodically.
9. That some service providers may take administration fees from your 403(b) account.
10. When provided all required information in a timely manner, OMNI is responsible for determining that salary reductions do not exceed the allowable contribution limits under applicable law, and will complete MAC calculations as required by law.
11. To contact OMNI and complete the appropriate OMNI forms for any requests for distributions, loans, hardship withdrawals, account exchanges plan-to-plan transfers or rollover contributions. Processing fees for the foregoing transactions may apply.
12. This SRA is subject to the terms of the Services Agreement between OMNI and Employer, and to the Information Sharing Agreement between OMNI and the Service Providers.
13. This agreement supercedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

Part 5: Employee Signature (Mandatory)

I certify that I have read this complete agreement and that my requested salary reduction(s), if in excess of my base limit, represent(s) my wish to utilize any catch-up provisions for which I may be eligible. I further certify that I will notify OMNI in the event I begin contributing to another 403(b), 401(k) or 401(a) plan. I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the TSA or CA established by me under the Plan are enforceable solely by my beneficiary, my authorized representative or me.

Employee Signature: _____ Date: _____

Part 6: Acknowledgement and Representation of Sales Agent/Representative (Not Required to Submit SRA)

I agree to comply with all pertinent written directives regarding the solicitation of Employee. In the event I provide OMNI with an Employee's date of birth ("DOB"), I acknowledge and agree that I must provide accurate information based on documentation provided to me by the Employee. Furthermore, I understand that any DOB information I provide to OMNI is utilized by OMNI to calculate the Employee's Maximum Allowable Contribution limits, which must be accurate to keep the Employer's plan in compliance with IRS regulations. All indemnification or other responsibility for a claim or demand arising from an error in employee DOB I provide will be governed by the Information Sharing Agreement between my employer and OMNI.

Sales Agent/Representative Name: _____ Phone: _____

Email: _____

Signature: _____ Date: _____

☐ I wish the above named agent to be copied on all e-mail communications sent to the plan participant, including certificate(s) of approval, which may be associated with this transaction.

Part 7: Employer Acknowledgement (If Applicable)

Salary: _____ # of TSA/CA Pay Periods: _____ Effective Payroll Date: _____

Employer Name & Title: _____

Employer Signature: _____ Date: _____

Please return this agreement to Omni Financial Group, Inc., unless otherwise advised by your employer:

Omni Financial Group, Inc.
220 Alexander Street, Suite 400 • Rochester, NY 14607
Toll Free: (877) 544-OMNI • Fax: (585) 672-6194
Please visit our website at **www.omni403b.com**

An FSA or HRA can be used for healthcare costs, such as doctor co-pays, LASIK surgery, eyeglasses, contact lenses, orthodontics, certain over-the-counter medicines, prescriptions, and much more.

Put the power of healthcare savings into your own hands

Flexible Spending Accounts (FSAs) or Health Reimbursement Arrangements (HRAs), are great ways for you to take advantage of a pre-tax benefit account offered through your employer. These accounts are a simple way for you to save on out-of-pocket healthcare costs not covered by your insurance plan. With healthcare costs continuing to rise, why wouldn't you participate in an FSA or HRA?

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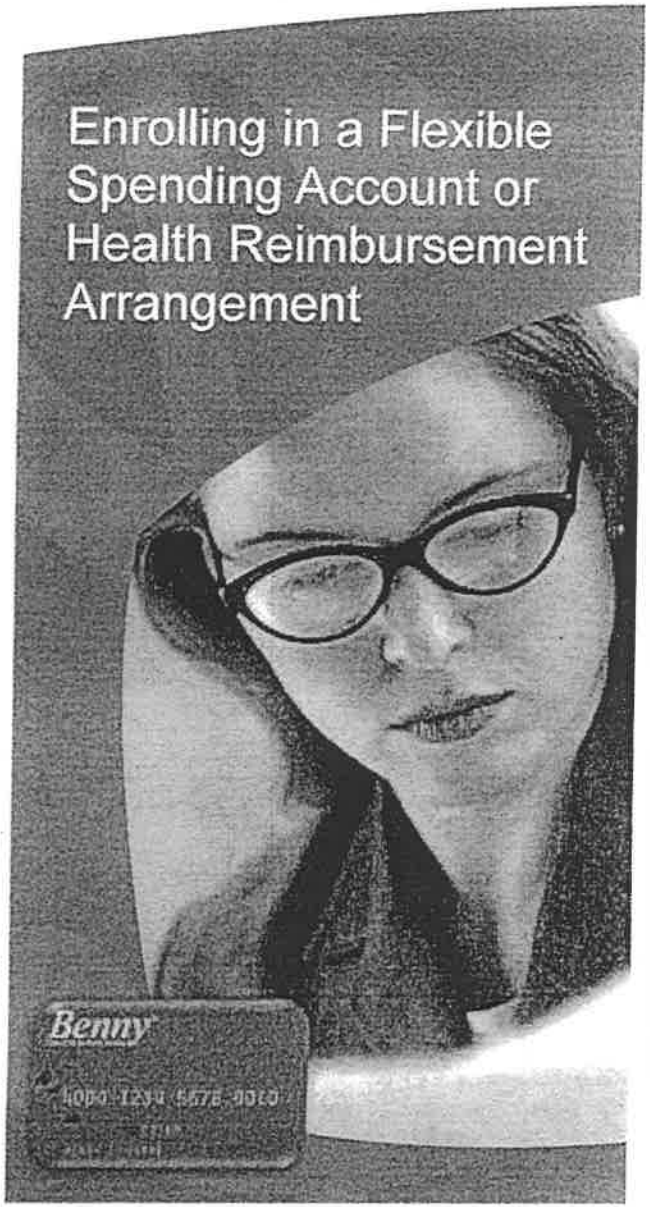
Save your card and card materials!

One Dodge Street
Wynantskill, NY 12198

(518) 283-8500 (800) 698-4753
(518) 880-4143 fax
www.benetechadvantage.com

Important Information About Your Prepaid Benefits Card



When you enroll in an FSA or HRA plan, every dollar you set aside in your plan saves you on taxes and increases your spendable income! You'll then enjoy the benefits of using these pre-tax funds for health-related, out-of-pocket costs not covered by your insurance.

Your Prepaid Benefits Card is loaded with the value of your annual FSA or HRA election amount (less any amounts you have already spent in this plan year)*. Using your Card helps you keep cash in your wallet and makes accessing your FSA/HRA funds easy. The Card can be used, instead of cash, to pay for qualified health care expenses.

The Benefits of your Benefits Card

You'll simply swipe your Card each time you incur a qualified health care expense and the amount of your purchase will be deducted from your FSA/HRA – automatically. You can also fill in your Card number on bills you receive from providers to pay the amount you owe for service dates within the plan year. You'll have no claim forms to complete and you won't have to wait to get a check in the mail.

You can check balances or account details anytime – online or with a quick phone call. It's that easy!

Remember, the card will not work at gas stations or restaurants – only at health care related providers.

IT'S IMPORTANT TO SAVE YOUR RECEIPTS!

Your Prepaid Benefits Card will definitely improve your cash flow. However, be aware that the IRS requires the Card be used only for eligible expenses. Most of the time, we can verify the eligibility of the expense automatically. **Yet, there are instances when you'll receive a letter/notification asking you to furnish an itemized receipt to verify the expense.** When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved.

WHAT IS AN ITEMIZED STATEMENT

An itemized statement must include: merchant or provider name, services received or item purchased, date of service, and amount of the expense. Cancelled checks, handwritten receipts, card transaction receipts or previous balance receipts cannot be used to verify an expense.

Dependent Care FSA

You can use your dependent care FSA to cover the same types of expenses that the IRS recognizes through dependent care tax credits. *Annual election amounts are NOT pre-loaded under Dependent Care, but are rather only available once funded via payroll contributions. Typical covered expenses include the following:

- Day care for child under the age of 13
- After-school caregivers
- Care for a disabled spouse or a dependent incapable of caring for self
- Care-related services (such as a visiting nurse)
- Summer day camps

QUALIFIED HEALTH CARE EXPENSE ARE:

- Prescription and health plan copayments, deductibles and coinsurance
- "Amount Due" on medical and dental statements
- Orthodontics
- Mail-order or online prescription invoices
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items

Know Your Benefits

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Manage your healthcare accounts from the palm of your hand.

Want to check your healthcare account balances and submit receipts from anywhere? There's an app for that! Benetech lets you easily and securely access your health benefit accounts, submit claims and upload receipts at any time. You have quick access to common tasks[1] with an easy-to-use design that helps make sense of your health and financial information.

Stay up to speed

With Benetech Benefits, you can get to the healthcare account information you need—fast. Wondering whether you have enough money to pay a bill or make a purchase? Benetech Benefits puts the answers at your fingertips.

- Quickly check available balances and account details for medical and dependent care FSA, HSA, HRA, VEBA, transportation and premium reimbursement plans
- View charts summarizing account information
- Set account alerts and get notifications via text message
- View claims requiring receipts
- Link to an external web page to obtain helpful information such as a list of eligible expenses
- Retrieve a lost username or password
- Use your device of choice – including iPhone®, iPad®, iPod touch® and Android™ smartphones and tablet devices

Tap and take action

Make a payment, capture a receipt or take any number of actions – whether you're on the couch or waiting in line. With Benetech Benefits, you can get it done fast and enjoy the rest of your day:

- Submit claims for medical and dependent care FSA, HRA, VEBA, transportation and premium reimbursement plans
- Snap a photo of a receipt and submit with a new or existing claim, or store in your camera roll for later use in claim filing
- Request a distribution from an HSA account
- Contribute funds to an HSA account
- Access your account funds to pay yourself or someone such as doctor
- Add and store information on new payees
- Enter and view expense information and receipts
- Report a debit card as lost or stolen

[1] Some functionality listed may require additional products or services.

Imagine what you could do with Benetech Benefits!

Get Reimbursed Quickly

Let's face it – no one *really* likes to visit the doctor, dentists, pharmacy or other healthcare provider. But sometimes you do and you may forget to use your health benefits card. So, when you pay for a qualified medical expense using your own money, you want to maximize your dollars and be reimbursed from your pre-tax account. File a claim with a receipt or request a distribution from your HSA soon after it happens. Right from your phone. Right from wherever you are. Get the payment process started.

Track Receipts

Why is it that the one receipt you need is always the one you can't find? With Benetech Benefits, you can record a health expense and capture the receipt the moment the transaction happens. That's peace of mind with a touch of a button.

Check Balances

Wondering whether you can pay for an elective procedure or a mounting bill? Do a quick account check to see your current balance. No need to wait for an answer – it's right at your fingertips.

Get started with Benetech Benefits in minutes.

Download on the App Store

ANDROID APP ON Google Play

*Download the Benetech Benefits app for your chosen device from the Apple App Store or Google Play and log in using the password you use to access the Benetech consumer portal.**

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**Never logged into the consumer portal? No problem! Your username will be your first initial, last name, and the last four digits of your Social Security Number (e.g., jsmith1234). The password will be 2013. Log in and create your unique PIN to make logging into the app quick and easy!*

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One Dodge Street
North Greenbush, NY 12198
(518) 283-8500

FLEXIBLE SPENDING ACCOUNT

EMPLOYEE/EMPLOYER ELECTION FORM/COMPENSATION REDUCTION AGREEMENT

COMPANY/CLIENT NAME		
EMPLOYEE NAME	DATE OF BIRTH / /	DATE OF HIRE / /
SOCIAL SECURITY NUMBER	EMPLOYEE PHONE NUMBER	
ADDRESS: STREET, CITY, STATE, ZIP		
EMPLOYEE EMAIL ADDRESS (REQUIRED)		

ELECTION:

First payroll date _____ **(REQUIRED Employer - Office Use Only)**

ACCOUNT	MIN. ELECTION	MAX. ELECTION	ANNUAL ELECTION	NUMBER OF PAY PERIODS	DOLLARS WITHHELD/PAY PERIOD
Unreimbursed Medical Account					
Dependent Care Account (Day Care Expenses for dependents up to Age 13)					

* In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.

DEPENDENT ENROLLMENT – List ALL dependents that can/will be eligible for reimbursements under Medical and/or Dependent Care accounts.

Dependent Name	Date of Birth (**required**)	SSN (**required**)	Relationship

PLEASE REFER TO YOUR SUMMARY PLAN DESCRIPTION REGARDING FORFEITURES, ROLLOVERS, AND GRACE PERIOD EXTENSIONS, AS THEY MAY APPLY TO YOUR PLAN.

Plan Notes:

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One Dodge Street
North Greenbush, NY 12198
(518) 283-8500

I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning ____/____/____, and ending ____/____/____. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked and I understand that election is required annually to participate. As a participant, I understand that:

- I cannot change or revoke this agreement during the above Plan Year, unless I have a change in my family status as set forth in the Summary Plan Description.
- My pay will be reduced each pay period by the amount of my election(s) shown on page 1, continuing for each succeeding pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my payroll reduction will automatically be adjusted to reflect that change.
- My employer may change the amount of my reduction or otherwise modify this agreement, if it believes that the change is required to satisfy provisions of the Internal Revenue Code.
- The amount of my compensation reduction will be credited to the appropriate reimbursement account for payment of eligible expenses incurred within the plan year.
- Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer, on demand, for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense that I receive.
- **Upon request, I will provide the Claims Administrator with the information (e.g., detailed receipts, itemized statements, etc.) needed to substantiate the expenses submitted for reimbursement, if needed by the Claims Administrator to satisfy the relevant IRS regulations, and that my failure to provide the required documentation will result in the deactivation of my debit card and a repayment request.**
- If there is a remaining balance in my account(s) at the end of the Plan Year (i.e., after all eligible claims have been reimbursed), I may forfeit that excess amount, based on the provisions of the Plan as detailed in the Summary Plan Description.
- By my signature, I hereby certify that any amounts reimbursed to me under this Plan will not be claimed as a deduction on my personal income tax return and will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan

PLEASE NOTE: The pay reductions will not be effective for any pay period that begins before you have signed this form and returned it to your Employer. Please keep a copy of this form for your records.

CHANGES/TERMINATIONS (Employer – Office Use Only)

Date of Event: ____/____/____
First paycheck date that change will be processed: ____/____/____.

___ Marriage/Divorce
___ Birth/Death of Spouse or Dependent
___ Spouse's employment commenced/terminated
___ Status change from full-time to part-time or part-time to full-time by employee or spouse
___ Unpaid leave of absence by employee or spouse
___ Open Enrollment
___ Employment Termination

Employee Signature_____ Date_____

Employer Signature _____ Date _____

HUMAN RESOURCES – OFFICE USE ONLY (ALL FIELDS REQUIRED)

Highly Compensated ☐ Y ☐ N
Key Employee ☐ Y ☐ N
Officer ☐ Y ☐ N
Spouse or Dependent of Owner ☐ Y ☐ N
More than 5% Owner ☐ Y ☐ N
More than 1% owner with salary greater than $150,000 ☐ Y ☐ N

GROUP INSURANCE PLANNING
benetech
P.O. Box 348
Wynantskill, NY 12198
(518) 283-8500
800-698-4753
www.wedobenefits.com

Flexible Spending Account/HRA Direct Deposit Authorization Form

PARTICIPANT INFORMATION

Employer Name: _____

_____

Participant Full Name: _____

(Exactly as it appears on the checking account.)

Participant Social Security Number: _____

Participant Phone Number: _____

Participant Email Address (Required): _____

ACCOUNT INFORMATION

Bank Name: _____

Account Number: _____

Routing Number: _____

AGREEMENT

I hereby authorize Benetech to deposit applicable Flexible Spending Account/HRA reimbursements into the bank account listed above. I understand that I may discontinue this payment service at any time by notifying Benetech in writing.

Participant Signature: _____ Date: _____

(Must be an authorized signer on the checking account.)

*Participant must include a voided or cancelled check with the account information above to complete this authorization.