FAIRFIELD PUBLIC SCHOOLS

TO: Fairfield Public Schools Staff

FROM: Payroll Department

DATE: March 16, 2016

SUBJECT: Pre-Tax or Post-Tax Option for Insurance Premium Cost Share

The purpose of the Pre-Tax Employee Contribution Option is to help you reduce your Federal and State Income Tax and reduce your Medicare/FICA liability (if any). Under the plan, all payroll deductions for **employee health insurance premiums** will be taken from your gross salary BEFORE TAXES are calculated. This process reduces your gross income (for tax purposes) by the pre-tax deduction, thus reducing the taxes you pay. The Pre-Tax employee Contribution Option is available for all employees who are enrolled in Medical/Rx and/or Dental insurance. In order to have pre-tax deductions you must fill out and sign the attached Enrollment Form.

IMPORTANT:
Complete and return this form to the **INSURANCE DEPARTMENT BY THURSDAY, APRIL 7, 2016.** This is the **only** enrollment period for the 2016-2017 fiscal year. DUE TO FEDERAL REGULATIONS, NO APPLICATIONS CAN BE ACCEPTED AFTER THAT DATE FROM CURRENT EMPLOYEES. **New employees who are eligible for this plan may join at the time of hiring regardless of the date.**

THIS PLAN IS NOT BENEFICIAL TO EVERYONE. YOU SHOULD BE AWARE OF THE FOLLOWING IMPORTANT INFORMATION:

1. Your eventual Social Security benefit may be slightly reduced. The impact is greater as you near retirement age. For certain individuals, the current tax savings may be worth more than the lost Social Security benefit.

2. **Because the Pre-Tax Contribution Option is governed by IRS regulations, you will not be able to change the tax status of your medical deductions after the plan year begins unless you have a change in family status, or there is a change in your spouse's employment.**

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Pre-Tax or Post-Tax Option for Insurance Premium Cost Share

COMPENSATION REDUCTION AGREEMENT

ALL EMPLOYEES MUST COMPLETE AND RETURN THIS FORM WITH YOUR ENROLLMENT FORM. IF YOU CHOOSE THE PRE-TAX OPTION, THE DESCRIPTIONS "HLTH PRE" or HEALTH PRE", "RX PRE and/or "DNTL PRE" or DENTAL PRE" APPEAR ON YOUR CHECK STUB.

IF YOU DO NOT RETURN THIS FORM
YOU WILL AUTOMATICALLY BE ENROLLED IN THE POST-TAX OPTION.

Name:_____Employee ID Number: _____

Address: _____

School: _____Position:_____

I have enrolled for certain benefits under the Health Insurance Benefits Plan.

YOU MUST SELECT ONE OF THESE OPTIONS:

____I elect premium cost share deductions on a **PRE-TAX** basis.

____I elect premium cost share deductions on a **POST-TAX** basis.

Compensation Reduction Agreement

Fairfield Public Schools and I agree that my compensation will be reduced by the amount of my required contribution for the benefit options that I have elected under the Pre-Tax Employee Contributions Option, as of the effective date of the Plan, and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution and the period that it is effective is set forth on a schedule that has been provided to me.

I understand that:
I cannot change or revoke this compensation reduction agreement, unless I have (a) a change in family status as set forth in the Pre-Tax Employee Contribution Option (b) the cost to me to receive the benefits significantly increases, (c) or the benefits, insofar as they are provided through insurance or health maintenance organizations, are significantly curtailed or cease during the Plan Year. If my required contributions are increased or decreased, my pay reduction will automatically be adjusted to reflect that increase or decrease. However, if such increase is significant within the meaning of Internal Revenue Service regulations, then I will have the right to change or revoke this compensation reduction agreement. If I revoke my election hereunder, I may receive coverage under another health plan sponsored by the Employer, if one is available, that offers similar coverage.

Prior to the start of each plan year, I will be offered the opportunity to change my enrollment forms for the following Plan Year. If I do not complete and return new enrollment forms at that time, I will be treated as electing to continue my benefits coverage then in effect for the new Plan Year.

The Plan Administrator may reduce or cancel the amount of my compensation reduction or otherwise modify this compensation reduction agreement in accordance with the Pre-Tax Employee Contributions Option if it believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this compensation reduction agreement will be in addition to any reductions under other agreements or benefits plans.

Date:_____ _____

Signature of Employee