Section 125 Cafeteria Plan Enrollment Form
Salary Reduction Agreement

BAY BRIDGE ADMINISTRATORS

Sutter Union High School District	July 1, 2026
Employer	Plan Year Start Date

First Name	MI	Last Name	SSN

Street Address	City	State	ZIP Code

Phone	Email	Hire Date

☐ **YES**, I WISH TO PARTICIPATE IN THE SECTION 125 CAFETERIA PLAN PROVIDED BY MY EMPLOYER. Please pay all eligible payroll deducted premiums (below) BEFORE taxes through the Section 125 Cafeteria Plan.

☐ **NO**, I WISH TO WAIVE MY RIGHTS TO PARTICIPATE IN THE SECTION 125 CAFETERIA PLAN AT THIS TIME

PAY PERIODS (DEDUCTIONS) ☐ **Weekly (52)** ☐ **Bi-Weekly(26)** ☐ **Semi-Monthly(24)** ☐ **Monthly(12)**

BENEFIT & PROVIDER NAME	PRE-TAX AMOUNT PER PAY PERIOD	POST-TAX AMOUNT PER PAY PERIOD	# OF DEDUCTIONS	ANNUAL AMOUNT
Health Flexible Spending Account				
Dependent Care Spending Account				

I agree that the amount by which my compensation is reduced may increase or decrease over the period, of which this election is effective to reflect changes in the cost of my insurance Coverage. I agree that my salary reduction election for insurance premiums only shall remain in effect from year to year until I revoke it. I understand that I may revoke my election to participate only at the end of a Plan Year unless there is a qualifying change in my family status (e.g., marriage, divorce, death, birth, adoption, change of employment or significant change in premiums/coverage) and I make the change within 30 days of the event.

I hereby acknowledge notification of all benefits under the Plan. I understand that the selection of an insurance benefit does not necessarily include me in the Plan. I understand that an application for insurance coverage must be completed and a policy issued as requirements to be included in the Plan. I hereby release my employer, its officers, agents and employees from any legal liability or obligation for any cause or reason in connection with this Plan, except for willful misconduct or gross neglect.

I understand that the Dependent Care Credit available under IRC Section 21 might be more advantageous than the Section 129 Dependent Care Credit Tax exclusion under the Plan. I understand that any elected amounts for reimbursements in either the Medical Expense Reimbursement or Dependent Care Reimbursement accounts, which are not incurred in the Plan Year or claimed by the end of the grace period, are forfeited to the Plan. I agree *not* to claim these expenses on my IRS Form 1040. I understand that funds cannot be shifted from on Flexible Spending Account to another.

Signature	Date	Enroller's Signature

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