PLUMAS COUNTY

ELECTION OF OPTIONAL BENEFITS
AND COMPENSATION REDUCTION AGREEMENT
FOR PLAN YEAR JANUARY 1, 2015 THROUGH DECEMBER 31, 2015

****THIS FORM MUST BE RETURNED WHETHER THE EMPLOYEE IS ELECTING PARTICIPATION IN THE PLAN OR ELECTING NOT TO PARTICIPATE.****

NAME _____
Last, First Middle

SSN# XXX-_____-XXXX (for filing purposes) Department: _____

_____ I elect not to participate in the 125 Plan and will continue to receive my regular compensation in cash. **(If you choose this option, please sign waiver of participation on the back.)**

_____ I elect to participate in the 125 Plan and authorize the County to reduce my regular compensation by the amount of the required contribution for my health plan benefit options. **(If you choose this option, please sign the first signature line on the back.)**

This election document supersedes any previous election and compensation reduction agreement under the County of Plumas Section 125 Premium Only Plan.

Employee Health Plan Option:

_____ Operating Engineers Health Plan _____ CalPERS/PORAC

_____ AFLAC _____ Colonial

I understand that:

- If the required contribution for the health plan increases or decreases during the term of this agreement, my compensation reduction will automatically be adjusted to reflect the increase or decrease.

- I cannot change or revoke this benefit election or compensation reduction agreement at any time during the plan year, unless I have a change in family status (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of either you or your spouse and such other events as the Plan Administrator determines will permit a change or revocation of an election).

- The Plan Administrator may reduce or cancel the amount of my compensation reduction or otherwise modify this agreement in accordance with the County of Plumas Section 125 Premium Only Plan if he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

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

- Prior to the first day of each plan year I will be offered the opportunity to change my benefit election for the following plan year. A participant failing to return a completed election form to the Plan Administrator relating to the optional benefits described in Section 4.1 on or before the specified due date for any subsequent Plan Year shall be deemed to have made the same election as was in effect as to such optional benefits just prior to the end of the preceding Plan Year.

- I have received a copy of the Summary Plan Description and Disclosure of the County of Plumas Section 125 Premium Only Plan.

- You should understand that by entering into the Compensation Reduction Agreement your tax contributions to Social Security will correspondingly be reduced, and this lower tax contribution may reduce your future Social Security retirement benefit.

THIS AGREEMENT, SUBJECT TO THE TERMS OF THE EMPLOYER'S 125 CAFETERIA PLAN, AMENDED FROM TIME TO TIME, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

Employee's Signature _____ Date _____

Accepted and agreed to by the Employer's authorized Representative.

By: _____ Date _____

WAIVER OF PARTICIPATION

This waiver will acknowledge that I have been informed of the terms of the above referenced Plan. Even though I am eligible to participate in such Plan, I hereby elect not to participate. I understand that this waiver will remain in effect for the remainder of the plan year for which this election is effective, but that I may again decide to participate in later plan years by making an election to participate during the election period prior to each plan year.

This waiver is effective for the plan year running from January 1, 2015 to December 31, 2015.

Employee's Signature: _____ Date: _____

Accepted and agreed to by the Employer's Authorized Representative.

By: _____ Date: _____

PLEASE RETURN THIS FORM TO THE HUMAN RESOURCES OFFICE