Stark County Government Cafeteria Plan Election Form

Employee Name: _____

I have reviewed the terms of the Stark County Government Cafeteria Plan ("the Plan"). (Capitalized terms used in this Election Form ("the Agreement") have the meanings set forth in the Plan document.) I understand that I may elect coverage, effective with the _____ calendar year, under the Premium Payment Component, under which I may opt out of Medical Benefits and be compensated at the rate of One Hundred Dollars ($100.00) per month so long as I am able to provide the Employer with proof of alternate insurance coverage or, should I elect Medical Benefits, elect to pay my portion of the premium payment for said Medical Benefits on a pre-tax basis.

Election of Benefits

I elect to receive the following coverage under the Plan:

☐ Cash Out / Opt Out Benefit: On separate benefit enrollment form(s), I have declined to enroll for Medical Benefits coverage. I instead have elected to be compensated at a rate of One Hundred Dollars ($100.00) per month and provide my Employer with proof of alternate insurance coverage. I understand that I have previously opted out of Medical Benefits offered by the Employer and I have elected to be compensated at a rate of One Hundred Dollars ($100.00) per month so long as I am able to provide the Employer with proof of alternate insurance coverage.

☐ Pre-Tax Premium Payment Benefit: On separate benefit enrollment form(s), I have enrolled for Medical Benefits coverage and I have received a schedule showing my share of the contribution for such coverage.

Elections Irrevocable Unless Exception Applies

I understand that I cannot change or revoke this Agreement as of any date prior to the next January 1, unless a Change in Election Event occurs as defined in the Plan (e.g. termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the Change in Election Event. This Election Form continues in perpetuity unless otherwise amended and/or until such time as I execute a new Election Form in accordance with the terms of the Plan and/or until such time as the Plan sponsor withdraws this benefit or sponsorship of the Plan.

Additional Terms

If indicated above by my election on this form, I agree that either my Compensation will be increased by One Hundred Dollars ($100.00) per month due to my election under the Plan, or my share of the contributions due for Medical Benefits coverage will be made on a pre-tax basis. I also understand that signing this Agreement does not decline my coverage under the Medical Benefits plan. I must complete a separate Medical Benefits enrollment form to decline my Medical Benefits coverage.

I have read and agree to the terms of participation and to any applicable certifications set forth in this Agreement. Any previous election and agreement under the Plan relating to the same Benefits, including any prior Election Form, is hereby revoked.

_____ _____

Employee's Signature Date

Accepted and agreed to:

_____ _____

Plan Administrator Date: