

***ADDISON NORTHEAST SUPERVISORY UNION
SECTION 125 PLAN***

Forms Kit

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**ADDISON NORTHEAST SUPERVISORY UNION
SECTION 125 PLAN**

Election of Benefits Form

Name (Last, First, MI)		Date
Mailing Address		City, State, Zip Code
Social Security #	Plan Year	School
Telephone number:		E-mail address:
ELECTION OF HEALTH CARE REIMBURSEMENT		
<input type="checkbox"/> I elect to participate in the Health Care Reimbursement Account for the plan year. (See the "Health Care Reimbursement Worksheet" and list on "Qualifying Expenses") NOTE: <i>Your contribution to the Health Care Reimbursement Account for _____ is limited to \$ _____.</i>		
1. Amount to be deducted each pay period: \$ _____ 2. Number of pay periods in the Plan Year: x _____ 3. Total for Plan Year (1 x 2): \$ _____		
<input type="checkbox"/> I elect NOT to participate in the Health Care Reimbursement Account.		
ELECTION OF DEPENDENT CARE ASSISTANCE		
<input type="checkbox"/> I elect to participate in the Dependent Care Assistance Account for the plan year. The maximum amount which may be allocated to the Dependent Care Assistance Account is \$5,000. (This limit may be reduced if you are married and you or your spouse are not employed full time or your spouse is a full-time student or your spouse is unable to care for him/herself. Please see the Plan Administrator for details.)		
1. Amount to be deducted each pay period: \$ _____ 2. Number of pay periods in the Plan Year: x _____ 3. Total for Plan Year (1 x 2): \$ _____		
<input type="checkbox"/> I elect NOT to participate in the Dependent Care Assistance Account.		
WAIVER OF PREMIUM CONVERSION		
All employee-paid health, dental and group term life insurance premiums will automatically be paid through the Addison Northeast Supervisory Union Section 125 Plan unless you elect not to participate.		
STOP : <i>Consider your response. Checking this box may not do what you think it will do. Most employees elect to participate in this part of the plan by NOT checking the box. Check this box only if you do not want your insurance premiums deducted on a pre-tax basis.</i>		
<input type="checkbox"/> I elect NOT to participate in the Premium Payment part of this Plan. This means that all employee-paid premiums will be paid with after-tax dollars, thus receiving no payroll tax savings.		
Please read the "Other Terms and Conditions Statement" On page 2 before signing below		
Employee's Signature:		Date:

Other Terms and Conditions Statement

I understand that: I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the plan year unless I have a change in status. A change in status includes marriage, divorce, annulment, death of a spouse or dependent, birth, adoption or placement for adoption of a child, change of my employment status or that of my spouse or dependent, my or my spouse's or dependent's change in residence or worksite, change in dependent care cost due to a change in provider or fees (fees not applicable if the care provider is a relative), my spouse's or dependent's change in coverage under their employer's Section 125 Plan or other qualified plan (change is not applicable to the health care reimbursement account), my or my spouse's or dependent's change in eligibility for Medicare or Medicaid, or such other events as the Plan Administrator determines will permit a change or revocation of an election. A change must be necessitated by and consistent with the change in status.

The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The redirection in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

The amount of my compensation redirection for each pay period during the year will be credited to reimbursement accounts or used to pay premiums on insured benefits and such amount will be paid on my behalf or I will be reimbursed, up to the balance in that account, for the applicable expenses incurred during the plan year.

Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits for me in a later plan year.

Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.

Premium Payments for employee-paid insurance premiums offered in this Plan will automatically be paid through this Plan unless I elect **not** to participate prior to the beginning of the Plan Year. Furthermore, I understand that my Employer will furnish me with an "Election Not to Participate" form upon my request.

Health care reimbursement will be available for "*qualifying medical care expenses*." Generally, "*qualifying medical care expenses*" are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). 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 to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state and local income tax or social security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

If I cease my employment with the Employer, my participation in the Health Care Reimbursement Account will continue if I so elect. If I elect to continue participation, my salary redirections will continue with after-tax contributions for the remainder of the plan year. If I elect not to continue participation, no further contributions will be made to the Plan on my behalf, although I may submit claims for expenses incurred during the plan year prior to my date of termination.

I cannot seek reimbursement from this Plan for a medical expense which I intend on taking as a deduction on my tax return.

Dependent care reimbursement will be available only for "*qualifying dependent care expenses*," as described in the Internal Revenue Code Section 129, the plan document and the Summary Plan Description. 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 to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state and local income tax or social security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

I agree to provide the Plan Administrator with the name, address and the taxpayer identification number of my dependent care service provider (if applicable).

I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance plan.

My reimbursement account elections will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before reduction hereunder, is at least equal to the amount of that reduction.

This agreement is subject to the terms of the Addison Northeast Supervisory Union Section 125 Plan, as amended from time to time in effect, 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 redirection agreement relating to such plan.

ADDISON NORTHEAST SUPERVISORY UNION

SECTION 125 PLAN

PERSONAL INFORMATION

We will need the following information for all employees participating in either Health Care Reimbursement, Dependent Care Assistance and/or the Privately Purchased Insurance Account (if applicable): **Also, due to privacy issues, we will only discuss your account with you unless we have this signed form.**

Your Name:	
Mailing Address:	
City, State, Zip Code:	Phone:

Marital Status:	
(Please Circle)	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union * <input type="checkbox"/> Domestic Partner*
* Civil Union and Domestic Partner's expenses are not eligible for reimbursement under a Cafeteria, Section 125, Flexible Benefits Plan	

List all eligible dependents including your spouse (do not include yourself):

Full Name	DATE OF BIRTH	M/F	SOCIAL SECURITY NO.	RELATIONSHIP TO YOU
John/Jane Doe	00/00/00	M/F	008-00-0000	Spouse

Those named above, **are** ____, **are not** ____ (check one) authorized to discuss the status of my reimbursement accounts, including payments of benefits with Future Planning Associates, Inc.

Signature:	Date:
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Please return this form to Future Planning Associates, Inc.

Health Care Reimbursement Worksheet

This worksheet will help you estimate your annual medical costs which may not be reimbursed by insurance. This list is not intended to be comprehensive, but it contains some of the more common medical expenses. Please review the attached list for additional qualifying health care expenses.

List all costs expected to be incurred by you, your spouse or qualified dependents that are not reimbursed by insurance.

Estimated Health Care Qualifying Expenses	Annual Expense
Medical doctor's fees	\$ _____
Annual physical examinations	\$ _____
Dental examinations	\$ _____
Eye examinations	\$ _____
Eyeglasses	\$ _____
Contact lenses	\$ _____
Drugs: prescription and over-the-counter (OTC)	\$ _____
X-rays	\$ _____
Lab fees	\$ _____
Hospital services	\$ _____
Chiropractors	\$ _____
Hearing aids	\$ _____
Surgery	\$ _____
Ambulance service	\$ _____
Nursing home costs	\$ _____
False teeth	\$ _____
Psychiatrists	\$ _____
Psychologists	\$ _____
Acupuncturists	\$ _____
Orthodontists	\$ _____
Total Annual Allowable Expenses	\$ _____
Number of pay periods	÷ _____
Amount of reduction per pay period	= \$ _____

Qualifying Expenses

Dependent Care Expenses

Expenses necessary for you to be gainfully employed:

- Expenses paid to a dependent care provider (includes day care)
- Expenses paid for care of a dependent under age 13
- Expenses paid for care of any dependent who is physically or mentally incapable of caring for himself

Health Care Expenses

Under the Health Care Reimbursement Plan, you will be reimbursed only for those types of medical expenses normally deductible on your federal income tax return (without regard to the 7.5% of adjusted gross income limitation). Only expenses **not** reimbursed by insurance can be claimed. See the reverse side of this form for a listing of qualified expenses.

Qualifying health care expenses include only those expenses incurred for:

- Yourself
- Your spouse
- All dependents you list on your federal tax return
- Any person that you could have listed as a dependent on your return if that person had not received gross income equal to or in excess of the exemption amount or had not filed a joint return.

IRS Publication 502, Medical and Dental Expenses, has a checklist of medical expenses that can be deducted and therefore reimbursed under this plan, and those that cannot. *Over-the-counter (OTC) drugs (e.g., aspirin, allergy and cold medications) purchased for medical purposes are an allowable expense under a Flex-125 Cafeteria Plan (although not deductible on your federal tax return.*

Qualifying Health Care Expenses

Health Insurance Premiums are NOT a Qualifying Health Care Expense

Air conditioning used for alleviating illness
Ambulance hire
Artificial limbs and teeth
Automobile modifications (hand controls, special equipment, mechanical lifts)
Birth control pills
Braille books and magazines
Childbirth preparation classes
Deductibles under your health & dental plans
Drugs (legal – prescription and over-the-counter (OTC)) and medical supplies
Elastic hose, medically prescribed
Eyeglasses and Contact Lenses

Fees:

Abortion
Acupuncture
Anesthetist
Blood donor
Chiropractor
Christian Science practitioners
Clinic
Dentist
Diagnosis
Diathermy
Examination, physical
Eye examination
Gynecologist
Healing services
Hospital
Laboratory
Lip reading lessons for the deaf
Medical information plan
Midwife
Nurse
Ophthalmologist
Optician
Optometrist
Oral surgery
Orthodontists* (with limitations)
Osteopath
Pediatrician
Physician
Physiotherapist
Podiatrist

Fees (continued):

Practical Nurse
Psychiatrist
Psychologist
Psychoanalyst
Sex therapist
Specialist
Surgeon
Therapy, weight loss program where prescribed as treatment for a specific disease
Food and beverages (special) for specific ailments when medically necessary and only to the extent that costs exceed normal diet
Halfway house residency
Health spa in home (to extent value of home not increased)
Hearing devices and Hearing Exams
Hospital bills
Iron lung, operating cost
Laetrile, when prescribed by doctor
Lifetime care at medical facility
Nursing care expenses
Obstetrical expenses
Operations and related treatments
Oxygen equipment
Rental of medical or healing equipment
Retirement home fees, portion allocable to medical care
Sanitarium or rest home
Seeing-eye dog and hearing-assisting cat (including maintenance)
Special education
Special television set to receive closed captions
Support or corrective devices (including special mattress and board for arthritis)
Swimming pool fees for use of pool for exercises prescribed by a physician to alleviate specific medical conditions
Telephone for deaf
Therapy treatments
Transportation expenses relative to illness
Vasectomy
Wood clapboard in home to treat allergy
X-rays

See IRS Publication 502 for additional information. **Caution:** some expenses listed in Publication 502 are not eligible for reimbursement under this plan due to IRS Regulations. Check with your Plan Administrator if you have any questions.

* Cosmetic surgery and orthodontics are limited to medically necessary procedures.

Eligible Over-The-Counter (OTC) Medicines and Drugs (Updated 12/03)

Some Over-The-Counter Medicines and Drugs are eligible to be reimbursed under a Section 125, Flex, Cafeteria Plan's Health Reimbursement Account.

OTC Medicines and Drugs must be purchased for medical purposes only for you, your spouse and/or dependents. Claims must be accompanied by a receipt or invoice with the name of the OTC item, medicine or drug as well as the date of purchase. As with other eligible expenses, purchase and use of the items must be incurred within the current Plan Year.

Eligible Items:

- Allergy medications
- Antibiotics
- Anti-diarrhea medications
- Anti-fungal medications
- Antihistamines
- Aspirin and other pain medications
- Asthma medications
- Bandages, gauze pads, rubbing alcohol, liquid adhesives
- Bug bite medications
- Carpel tunnel wrist supports
- Cold/hot packs for injuries
- Corn/callus removers
- Cough drops
- Decongestants
- Eye products (including non-prescription reading glasses)
- First aid creams (diaper, fever blister, cold sores, poison ivy, sunburn)
- Heartburn medicines
- Hemorrhoid treatments
- Laxatives
- Menstrual cycle products for pain and cramp relief
- Motion sickness treatments
- Muscle or joint pain treatments or medicines
- Nasal sprays
- Nasal strips
- Nicotine gum or patches for smoking cessation purposes
- Sinus medications
- Thermometers/accu strips
- Throat lozenges
- Topical creams for pain relief
- Wart removers

Some items, such as vitamins, botanicals/herbs, feminine hygiene products, hormones, minerals and sunscreens would require a medical doctor's "letter of medical necessity" to be eligible for reimbursement.

Other items and medicines (drugs) may be eligible or become eligible. This is a new opportunity; we will update this list as more information becomes available.

Some items, such as cosmetics, toiletries and items used primarily for your general health and well-being are not a permitted expense.

Dependent Care Assistance Account Worksheet

Use this worksheet to estimate your tax savings with the Dependent Care Assistance Account and compare to your tax savings under the Federal Dependent Care Tax Credit. Please note, this is a general worksheet. Consult your tax advisor if you have questions about your individual situation.

Income and expenses

- a) Enter your total annual income (for you and your spouse, if applicable) before taxes but after deductions (a)
\$ _____
- b) Enter the estimated cost of child and dependent care for the upcoming year (b)
\$ _____

Dependent Care Assistance Account Tax Savings

- c) Determine your estimated Federal and Social Security/Medicare tax rate:
- Enter your estimated Federal income tax rate: _____ %
Enter your estimated State income tax rate: _____ %
Add 7.65 if your estimated income is \$97,500 or less (for 2007)*: _____ %
Add 1.45 if your estimated income is greater than \$97,500 (for 2007)*: _____ %
- Your estimated total Federal, State, and Social Security/Medicare Rate (sum the above percentages and enter on (c): _____ % (c)
\$ _____ %
- d) Enter the amount in item (b). If married, you may not claim more than the earnings of the lower paid spouse. The maximum amount that can be claimed is \$5,000 per year (\$2,500 if you are married and filing separately). Special rules apply to employees with spouses who are incapacitated or are full-time students at least five months during the calendar year: (d)
\$ _____
- e) Multiply the expenses in item (d) by the percentage in item (c) to estimate the tax savings from the Dependent Care Assistance Account: (e)

* The 2007 Social Security Tax is 7.65% of the first \$97,500 of taxable earnings. On earnings in excess of \$97,500, the Social Security Tax is reduced to 1.45%

Federal Child and Dependent Care Tax Credit

f) Enter the amount in item (b) subject to the following maximums:
If one child or dependent: \$3,000; if two or more, \$6,000; if married,
you may not claim more than the earnings of the lower paid spouse:

(f) \$ _____

g) Based on the total gross annual pay you and your spouse (if any)
earn, select the appropriate tax credit from the table below:

(g) \$ _____

Total Gross Annual Income	Tax Credit
Up to \$10,000	30%
\$10,001 to \$12,200	29%
\$12,001 to \$14,000	28%
\$14,001 to \$16,000	27%
\$16,001 to \$18,000	26%
\$18,001 to \$20,000	25%
\$20,001 to \$22,000	24%
\$22,001 to \$24,000	23%
\$24,001 to \$26,000	22%
\$26,001 to \$28,000	21%
\$28,001 and Up	20%

h) Multiply item (f) by the percentage in item (g) to estimate the
Federal Child and Dependent Care Tax Credit:

(h) \$ _____

Making Your Decision

Compare item (e) to item (h). If the tax savings in (e) is greater than the Federal Tax Credit in (h), your Dependent Care Assistance Account will save you more money than the Federal Tax Credit. If the Federal Tax Credit in (h) is greater than the Dependent Care Assistance Account tax savings in (e), then you should not enroll in a Dependent Care Assistance Account. Be sure to talk to a tax advisor if you have any questions about your individual situation.

Summary

A Dependent Care Assistance Account is easy to use and can save money starting with your first paycheck. Unlike the child and dependent care tax credit, which is not available until you file your federal return, a Dependent Care Assistance Account reduces your taxable income right away. And, in most cases, the savings from a Dependent Care Assistance Account exceed the savings from the federal tax credit. Please note: tax savings may not be the only factor to consider when making this decision.

Notes:

- 1) You may use a combination of the Assistance Account and tax credit. However, any amount you deposit to the Assistance Account will be deducted from the maximum you are eligible to use in claiming a tax credit.
 - 2) Services must be provided for someone under age 13 or a qualified* dependent (including eldercare).
 - 3) If you take advantage of either the Assistance Account or the tax credit, you must provide the name, address, and taxpayer identification number of your dependent care provider on your reimbursement form and on your annual federal tax return.
 - 4) If you contribute to a Dependent Care Assistance Account, your employer will include your dependent care reduction on your Form W-2 for IRS reporting purposes only. This amount is tax free. You will need to submit IRS Tax Form 2441 (parts I and III) each year if you participate in the Dependent Care Assistance Account.
- Over the age of 12 (either a child or dependent adult) and physically or mentally incapable of self-care.

**ADDISON NORTHEAST SUPERVISORY UNION SECTION 125 PLAN
Dependent Day Care Expense Claim Form**

Name (last, first, MI)	Social Security #
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Name of Dependent(s):

Period of Care: _____ through _____

Amount Requested (care provider complete Affidavit section below or attach receipts or invoices):

Service Provider Information

Name:

Address:

Provider's Tax ID# or Social Security #:

Description

Affidavit of Dependent Care Services Rendered

I have provided adult/child care for _____ for the period beginning _____ and ending _____. Services were provided to _____ for a fee of \$ _____

Signature of Care Giver	Tax ID# or SS#	Date
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N O T E The total amount claimed under the plan must not exceed the lesser of your wages or salary for the plan year, or the wages or salary of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of \$200 if there is one child or dependent, and \$400 if there are two or more.) No payment may be made under the plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

I M P O R T A N T The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period in which the undersigned was covered under the Addison Northeast Supervisory Union Section 125 Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal and state income taxes and social security taxes on amounts paid from the plan which relate to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.

Participant's Signature	Date
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Please return completed form to:
 Future Planning Associates, Inc.
 ATTN: Addison Northeast supervisory Union Section 125 Plan Administrator
 P.O. Box 905
 Williston, Vermont 05495-0905

FAX: 802/878-9455 – If faxing this request, to avoid duplication, DO NOT mail.

• This form must reach Future Planning Associates, Inc. by noon on the 24th of each month •
 •Disbursements are paid the following month •

**ADDISON NORTHEAST SUPERVISORY UNION
SECTION 125 PLAN**

Health Care Expense Claim Form

Name (last, first, MI)	Social Security #
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The undersigned Participant in the Plan requests reimbursement in the amount shown below (please list individually on the reverse side):

Please attach the following documentation for each expense (**do not send cancelled checks or credit card receipts /statements, as they are not considered acceptable evidence**):

- **Services or products covered by any other benefit plan** (i.e., health insurance plan): Explanation of Benefits Statement (EOB), or
- **Services or products NOT covered by any other benefit plan:** invoices or receipts which indicate the name and address of the service provider, name of employee or dependent for whom the service was provided, **date of service**, type of service or product provided and amount of expense.

Total Amount of Medical Expenses (from page 2 of this form):

I M P O R T A N T	The undersigned participant in the plan certifies that all expenses for which reimbursement or payment are claimed by submission of this form, were incurred during a period in which the undersigned was covered under the Addison Northeast Supervisory Union Section 125 Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made. Furthermore, the undersigned agrees that any amounts paid which are in excess of his or her current account balance will be considered a loan and will be owed to the Plan in the event he or she terminates employment (for any reason) prior to the completion of the current Plan Year.
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Participant's Signature	Date
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Please return completed form to:
Future Planning Associates, Inc.
ATTN: Addison Northeast Supervisory Union Section 125 Plan Administrator
P.O. Box 905
Williston, Vermont 05495-0905

FAX: 802/878-9455 – If faxing this request, to avoid duplication, DO NOT mail.

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· Disbursements are paid the following month ·**

**ADDISON NORTHEAST SUPERVISORY UNION SECTION 125 PLAN
Revocation of Benefit Election
and Compensation Redirection Agreement**

Name (last, first, MI)		Social Security #	
I hereby revoke my benefit election and compensation redirection agreement under the ADDISON NORTHEAST SUPERVISORY UNION Section 125 Plan with respect to the following coverage(s):			
Non-Insured Coverage		Insurance Coverage	
<input type="checkbox"/> Health Care Expense Reimbursement <input type="checkbox"/> Dependent Care Assistance	<input type="checkbox"/> Health Insurance <input type="checkbox"/> Dental Insurance <input type="checkbox"/> Group Term Life Insurance		
Change in Status		Change In Status continued	
<input type="checkbox"/> Dependent Care cost change due to change in provider or fees (fee change not applicable if care provider is a relative) <input type="checkbox"/> Spouse 's or dependent's change in coverage under their employer's cafeteria or other qualified plan (change is not applicable to the health care reimbursement account) <input type="checkbox"/> Your, your spouse's or dependent's change in eligibility for Medicare or Medicaid	<input type="checkbox"/> Marriage, Divorce, Annulment <input type="checkbox"/> Spouse or dependent dies <input type="checkbox"/> Birth, Adoption or Placement for Adoption <input type="checkbox"/> Your, your spouse's or dependent's employment status changes <input type="checkbox"/> Dependent's status changes <input type="checkbox"/> Your, your spouse's or dependent's change in residence or worksite <input type="checkbox"/> My spouse or I take an unpaid leave of absence		
This revocation is to be effective with paycheck date:			

I understand that the change in my benefit selection must be necessitated by and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury. My benefit election and compensation redirection agreement shall remain in effect as to my benefit coverage(s), if any, which are not checked above. I understand that this revocation may not be effective prior to the first day of the next plan year unless it is made because of a change in (family) status as defined in the Plan. In no event may the revocation be effective prior to the first pay period beginning after this form is completed and returned to the Plan Administrator.

I certify that I am making this election because of the change in (family) status indicated above.

Employee's Signature:	Date:
Accepted and Agreed to By:	Date: