CC: Payroll/Benefits File
Personnel File

ASHFORD BOARD OF EDUCATION
COMPENSATION REDUCTION AGREEMENT

Name ______________________________ S.S. # ____________________

Address ____

I have enrolled and receive certain medical insurance payments through my employment with the Ashford Board of Education.

__________ I hereby elect to receive those medical benefits under a Health Savings Plan Salary Reduction Agreement designed to exclude my share of health insurance premiums and employee contribution from taxable income.

__________ I do not elect to participate in the Health Savings Plan employee contribution.

The Ashford Board of Education and I agree that my taxable compensation will be reduced by the amount of my required contribution for my medical insurance benefits, as of the first pay period, and continuing for each succeeding pay period between the months of September and June until this agreement is amended or terminated.

I agree that my taxable compensation will be reduced by the amount of my employee contribution into my Health Savings Account. I choose to have $_________________ deducted per pay period. I understand the Ashford Board of Education will "fund 50% of the HSA Plan deductible for each year of this Agreement." (page 10, AEA Union Contract)

I agree to follow the instructions provided to me by the Payroll/Benefits Administrator to open my own Health Savings Plan account at Rockville Bank, and provide the routing number and account number to the Payroll/Benefits Administrator for deposits of my employee contribution and my employer match. I agree to do this in a timely manner, and by the due date of _________________.

I understand that I cannot change or revoke this compensation reduction agreement as of any date prior to the next plan year start date, unless I have (a) change in family status, (b) the cost to me to receive the benefits significantly increases, (c) or the benefits, insofar as they are provided are significantly curtailed or cease during the plan year.

Prior to the start of each plan year, I will be offered the opportunity to change. If I do not complete and return the new enrollment form at that time, I will be treated as electing to continue my original option. The Plan Administrator may reduce or cancel the amount of my compensation reduction or otherwise modify this compensation reduction agreement if he/she believes it is advisable in order to satisfy provisions of the Internal Revenue Code.

______________________________ ____________________
(SIGNATURE) (DATE)

FOR PAYROLL USE ONLY:

Received on: ______________________________ By: ______________________________

Effective Payroll Date: ________________________ Entered in ADP by: ______________________