BBP Admin
BENEFITS ADMINISTRATION
COBRA, FMLA, FSA, HRA, HSA, TRANSIT
info@bbpadmin.com
www.bbpadmin.com
630 773 2337

Individual Premium Plan

TAX-QUALIFIED INDIVIDUAL INSURANCE PREMIUM
ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT FOR
EMPLOYER'S CAFETERIA PLAN
20____ Benefit Plan Year

Employee Name: ____

Employee Address: ____

____
City State Zip

Social Security Number: ____ Date of Birth: __________________________

E-mail: ____ Phone: _______________________________

I hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period for the balance of this plan year. I understand this money cannot be used to pay for insurance premiums that I pay for myself, my spouse and/or children through another corporate sponsored insurance program.

Major Medical Premiums:

Employees cannot participant through this program for employee individual premiums. For spouse or qualified dependents Individual policies marketed through an Exchange cannot be offered as a qualified benefit under a cafeteria plan.

Non-Major Medical Coverage – (Dental/Vision/Hospital/Critical Illness/Life/Disability)

These are allowed as individual polices through the Cafeteria plan with no restrictions.

I understand this money will be redirected to insurance premium contributions to pay for qualified individual insurance expenses incurred by my family or myself. I understand I must maintain the coverage I have elected and notify the Plan Administrator if the premium changes during the plan year. I elect to fund and receive the following benefits available under the following plan:

ELECTION OF OUTSIDE INSURANCE COVERAGE:

	Annual Election	# of Pay Periods	Per Paycheck Amount
☐ Individual Insurance Premiums	$________________	_________________	$_________________

Name of Insurance Carrier: ____ Product: __________________

Names insured covered under the above plan: ____

I understand that I must furnish adequate proof of coverage and that the Administrator must authorize this payment.

OTHER TERMS AND CONDITIONS

I understand that:

- I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of spouse's employment) or such other events as the plan administrator determines will permit a change or revocation of an election.
- 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; such as discrimination testing.
- The reduction of my cash compensation under the agreement shall be in addition to any reductions under other agreements or benefit plans maintained by my Employer.
- If I select to be covered under the disability or life insurance through the Plan, then any benefits paid to me from such insurance will be fully taxable to me and that it will be my responsibility to include these amounts in my gross income.
- 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. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my insured benefit elections then in effect for the new plan year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the insured benefit option.
- 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 in a later plan year.
- At retirement, my social security benefits may be slightly reduced as a result of my election.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA 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(S).

Employee's Signature_______________________________________ Date: _________________

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

By: ____ Date: _________________

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