Redwood Health Services

Salary Redirection Agreement

For insurance premiums (POP Premium Only Plan) and/or medical expenses (HSA Health Savings Account)

Return this form to your employer, not to RHS.

Employer: _____ Employer Tax ID Number: _____

Address: _____ Plan Year: _____

Employee SS#: _____ If new employee or rehire, indicate eligibility date: _____

Name: (Last) _____ (First) _____ (Middle)_____

Address: _____ City/State:_____ Zip: _____

Payrolls in Plan Year: _____ Date of first deduction: _____ Payroll: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain insurance coverage(s) and understand that my employer or Third Party Payroll Administrator will deduct my insurance premiums or my HSA contributions from my paycheck. These deductions will occur either pre-tax or after-tax for the coverages that I elect below. The deductions will be continuous and in an amount equal to the insurance premiums for each payroll period for the entire plan year. The deductions cannot be changed during the plan year, unless the plan administrator determines that I have incurred a qualifying change in status for purposes of Code Section 125. Prior to the beginning of each plan year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. The amount of my required contribution is set forth on a schedule that will be provided to me. In the event of a change in premiums or HSA contributions during a plan year, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. I understand that pre-tax contributions reduce my compensation for Social Security tax purposes, and my Social Security benefits could be decreased. Any previous election and Salary Redirection Agreement relating to the same plan year are hereby revoked.

Check desired coverage(s) below:

Insurance Premiums								
	Pre-Tax	**After-Tax**		**Pre-Tax**	**After-Tax**		**Pre-Tax**	**After-Tax**
Medical	☐	☐	Cancer	☐	☐	Short-term disability**	☐	☐
Dental	☐	☐	Group Term Life*	☐	☐	Long-term disability**	☐	☐
Vision	☐	☐	Accident	☐	☐			

Medical Expenses		
	Pre-Tax	**After-Tax**
Health Savings Account	☐	☐

* If family coverage, you must select after-tax. Further, if you select pre-tax for employee coverage, the cost of life insurance in excess of $50,000 will be added back to your taxable wages.

** If you pay for disability coverage on a pre-tax basis, your disability benefits will be taxable. If you pay for disability coverage on an after-tax basis, your disability benefits will generally be received tax-free.

I certify that the features and benefits under the Code Section 125 Plan have been explained to me completely and that the above is true and accurate in all respects.

Employee's signature: _____ Date: _____

WAIVER OF PRE-TAX BENEFITS UNDER THE CODE SECTION 125 PLAN: I elect to waive all benefits under the Plan. Except for a "qualifying change in status," I understand that I cannot elect pre-tax benefits until the next plan year.

Employee's signature: _____ Date: _____