

AMHERST PLAN

ELECTION/ENROLLMENT FORM AND SALARY REDUCTION AGREEMENT

Name: _____ Amherst College ID Number: _____

Please check the appropriate boxes and fill in the annual amount you would like to contribute to a health and/or dependent care account.

- Payment of my portion of health insurance premiums before taxes. Please reduce my salary, in addition to any other reductions, by the amount of my portion of the premium. *(Once elected, this option will stay in force, year to year, until you choose to revoke it.)*

I elect the following Amherst Plan benefits for the Plan year ending June 30, 20____.

- Health Care Account. Please reduce my salary, in addition to any other reductions, by \$_____ **PER YEAR** (an amount which does not exceed the limits described in The Amherst Plan summary.)
- Dependent Care Account. Please reduce my salary, in addition to any other reductions, by \$_____ **PER YEAR** (an amount which does not exceed the limits described in The Amherst Plan summary.)

In making these elections, I understand and agree that:

- My salary will be reduced by the amounts selected above during the Plan year listed above (or the portion of the year remaining after the date of this agreement). Health Care and Dependent Care amounts do NOT carry over and must be re-elected each Plan year.
- My salary will be reduced and applied toward the benefits as described in The Amherst Plan summary, which are incorporated into this agreement by reference.
- **I cannot change or revoke this agreement during the Plan year unless there is a change in my status as described in The Amherst Plan summary. Changes, with documentation, must be submitted within 30 days of the status change date.**
- I will forfeit any unused money remaining in my account(s) on October 15th following the end of the Plan year indicated above.
- If I am reimbursed for health or dependent care expenses that are not eligible for reimbursement, I agree on demand to indemnify and reimburse Amherst for any liability it may incur for failure to withhold Federal and state income or Social Security taxes up to the amount of additional tax owed by me.
- This Agreement is subject to the terms of the Amherst Plan as from time to time are in effect.

Participant's Signature

Date: _____

Mailing Address

Date of Birth: _____

Received and agreed to by Amherst College

By: _____

Date: _____