MCP # 94970
Plan # 501
Effective Date: 9/1/2016
ID

Annual Re-service Letter

Employer Information

Name of Employer: **Dietrich School District #314**
Mailing Address: **406 N Park ST Dietrich ID 83324**
Telephone Number: **(208)544-2158**
Section 125 Contact Person: ~~**Peggy Wheeler**~~ Andrea Schaeffer
Employer Identification Number: **826003139**
Nature of Business: **Public School**
Business Entity Type: **Governmental Entity** (i.e. C-Corp, Sub S Chapter, Private School, Not-For-Profit etc.)
Name of Plan: **Dietrich School District #314**125 Flexible Benefit Plan (**Premium Only Plan**)
Plan Number: **501**
Plan Sponsor (if different than employer):
Is this plan for a collective bargaining unit? ☐ Yes ☒ No
If "Yes", please list the classification of the bargaining unit: ________________

Plan Information

Plan Year:

Original Effective Date of Section 125 Plan: **9/1/2012**

Upcoming Section 125 Plan Year: **9/1/2016** through **8/31/2017**

Eligibility Requirements (time worked required to be eligible for 125 Plan):

Length of Service: **First day of the month following employment.**
Minimum Number of Hours Worked Per Week: **20**
Minimum Age: **0**
Are retired employees eligible to participate? **No**

Plan Funding:

Non-Elective Contributions (the dollar amount or percentage of premium the employer contributes under the Section 125 plan to pay for the employer's share of the cost of a specific premium OR that the employee can apply towards any benefit offered under the plan):

$27,500 per employee per entire plan year

If the employee opts out of coverage, the employee **Will Not** receive the non-elective contribution as taxable compensation.

Aside from the above contribution, does the employer provide (or pay) a percentage of the premium of any benefit for the employees?
☒ Yes ☐ No

If "Yes", please specify the type of benefit and the cost of the premium (specify
Up to $430 a month toward health, dental, or vision insurance premiums.

if the employer provides individual or family coverage):

____
____
____
____
____

Elective Contributions (the maximum dollar amount or percentage of compensation an employee can have taken out of their pay to purchase pre-tax benefits for the plan year):

100% of Compensation Per Plan Year

Available Benefits Offered Under the Plan - If adding a carrier, please include the carrier name and a product description such as a group number or policy number. If insurance coverage is blank, there are no available carriers under this plan. The information may need to be updated or the coverage is listed on another plan.

Medical Insurance:

Aflac
Blue Cross HDHP

Disability Insurance:

Cancer Insurance:

Dental Insurance:

Vision Insurance:

Group Term Life Insurance: (includes group and individual term life meeting Section 79 requirements)

If group term life is available, the plan participant may not exceed $50,000 (the cost of amount in excess of $50,000 is taxable to the participant)

Please complete the following:
Does your employer provide group term life to its employees? ☐ Yes ☒ No
Do all employees have the same face amount? ☐ Yes ☐ No
If "Yes", what is the face amount for each employee? ______________

Flexible Spending Accounts:

Dependent Day Care Reimbursement:

Minimum Contribution Per Plan Year: $ **0**
Maximum Contribution Per Plan Year: $ **0**
Recordkeeper:
Eligibility for Coverage (if different than plan eligibility):

Medical Expense Reimbursement:

Minimum Contribution Per Plan Year: $ **0**
Maximum Contribution Per Plan Year: $ **0**
Recordkeeper:
Are Debit Card's available?
Eligibility for Coverage (if different than plan eligibility):

Does the Employer allow for the Grace Period? **No**

Does the Employer allow for the $500 Carryover Provision? **No**

If you would like to change the above information for the Medical Expense Reimbursement plan, please select one of the following options:

☐ We elect to allow for the Grace Period

☐ We elect to have the Carryover Provision of up to $500

☐ We do not elect the Carryover Provision or the Grace Period

Health Savings Account:

HSA Trustee: **American Fidelity Health Services Administration**

Limited Purpose Medical Expense Reimbursement Account available? **No**

Document Review

☐ THERE ARE NO CHANGES TO THE DOCUMENT INFORMATION
☐ THE NECESSARY REVISIONS HAVE BEEN MADE TO THE DOCUMENT INFORMATION. THE REVISIONS ARE TO BE EFFECTIVE ____________________
☐ AMERICAN FIDELITY IS NO LONGER OUR SECTION 125 PROVIDER EFFECTIVE ____________________

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If changes are necessary to your plan document:

☐ Please send the completed plan document(s) to me via *e-mail* at the following e-mail address: *(please print clearly)* andreas@sd314.k12.id.us

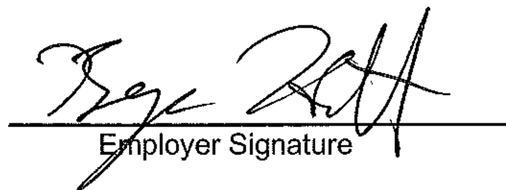
(To avoid downloading a computer virus, be aware that the documents will be sent as an e-mail attachment with the Subject Line of: Dietrich School District #314 Section 125 Plan Document)

☐ I am unable to utilize the option above. Please mail the completed plan document(s) to me.

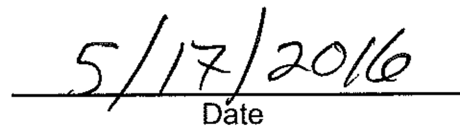
The employer should be aware that under Internal Revenue Service regulations, the Section 125 Plan should be in writing and adopted prior to the beginning of the plan year if there are any changes from the previous signed version.

If you should experience changes to your Section 125 Plan during the plan year (such as adding or deleting a benefit, a change in the plan year, change in funding, etc.), please contact the Section 125 Department at **WG-AcctAdmin-S125@AmericanFidelity.com** or by phone at (800) 662-1113 ext. 8904

*I have reviewed the above information and find it accurate to the best of my knowledge.



Employer Signature



Date

** If you have questions regarding the information contained on your plan document, please contact the Section 125 Department at (800) 662-1113 ext. 8904.*

For Home Office use only: Dietrich School District #314 (ID) MCP #94970 Plan #501 Plan Year: 9/1/2016