Attachment A

SALARY REDUCTION AGREEMENT
under the
WASHINGTON TOWNSHIP BOARD OF EDUCATION FLEXIBLE BENEFIT PLAN
ELECTION/CHANGE FORM

To: Bowman & Company LLP
P.O. Box 972
Voorhees, NJ 08043

Effective _____ (insert date salary reduction is to commence). I request my employer to reduce my taxable wages by the sum of the amounts noted below for the _____ calendar year. I understand that this total amount will be deducted pro rata during each payroll period over the year. The amount of this total reduction shall be allocated to my spending accounts as follows (check each spending account desired and fill in blank spaces as appropriate):

_____ Dependent Care Spending Account
Total Amount Requested ($5,000 max.) $_____

_____Medical Spending Account
Total Amount Requested ($3,000 max.) $_____

_____Health/Dental Premium Conversion Spending Account. I request that my taxable wages each pay period be reduced by my share of any health and/or dental insurance premiums payable under any employer-sponsored health plan in which I am a participant and that my employer use the salary-reduced amounts to pay my share of the premiums. I understand that my salary reductions for this benefit will automatically change due to changes in the premium arrangements (e.g., an increase in premiums or an increase in the share of these premiums I may have to pay).

_____ Initial yearly election _____ Revision _____ I do not wish to participate
Change in status (check one)

_____Legal Marital-Marriage, Death of Spouse, Divorce, Legal Separation or Annulment.
_____ # of Dependents-Birth, Adoption or Death.
_____Employment-Termination or commencement by Employee, Spouse or Dependent.
_____ Work Schedule-P/T, F/P, Strike, Reduction or increase in hours or unpaid leave.
_____ Change in Dependent's Status-Requirements for Coverage Due to Age, Student Status or Similar Circumstances.
_____ Residence or Worksite-Change for Employee, Spouse or Dependent.
_____ Cobra, Medicare or Medicaid
_____ Judgment, Decree or Order.
_____ Change in Cost of Coverage

I understand that this agreement is irrevocable except for certain changes specifically set forth in the plan documents. I also understand that amounts set aside in each Spending Account can be used only for the payment of expenses under that account. The amounts cannot be transferred from one account to another, carried over beyond the year to which this agreement relates or returned to me in cash or other remuneration. Failure to return this form will constitute a Default Election of Premium Conversion. I also understand that all unused monies in any Spending Account will be **forfeited**.

Dated: _____

_____ _____
Please print Employee's Name Employee Signature

For Administrator Use Only

Accepted on behalf of the Employer by: Dated: _____

_____
Signature of Employer
Authorized Representative

Rev.1214/05 kms