

**AGREEMENT FOR SALARY REDUCTION**

By this AGREEMENT, made between \_\_\_\_\_ (please print your name) and Suffolk University, the parties agree as follows:

Effective with respect to amounts earned on or after January 1, 200\_\_ (which date is subsequent to the execution of this Agreement), Suffolk University will reduce your annual salary by the amount(s) you indicate below. For administrative ease, this amount will be deducted from your pay in either 12 equal monthly installments or 48 equal weekly installments (spread over the first 4 weeks of each month), depending on your pay cycle. Your future Social Security benefits could be slightly reduced as a result of your participation in this Flexible Reimbursement Account (FRA) Plan.

If on December 31<sup>st</sup> following the plan year specified above dollars remain in the reimbursement account, they will be forfeited in accordance with IRS regulations. IRS regulations are very specific about the “use it or lose it” provisions. To protect yourself, you should be very careful in determining the amount you contribute to the FRA.

The amount of salary reduction for this calendar year shall be:

<u>Account</u> (Check one or both).	<u>Annual Contribution</u>
1. ____ Medical Reimbursement Account	\$ _____
2. ____ Dependent Care Reimbursement Account	\$ _____

**I understand that I cannot change my account selections or contributions during the plan year unless I experience certain changes in family or employment status in accordance with the IRS regulations.**

**I understand that my future participation in the plan will end upon my termination of employment unless I elect a COBRA contribution for which I may be eligible.**

Signature \_\_\_\_\_

Date \_\_\_\_\_