Flexible Benefit Plan Election Salary Reduction Form

Administered by:
Nyhart

Carthage Elementary School District #317

Plan Year: 7/1/23-6/30/24

Employee Information (please print or type)

Name (Last, First, MI) _____

Social Security Number _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Email _____

☐ I **Elect** to participate in the Flexible Spending Account for the Plan Year. I understand that my share of the premiums for the eligible plan(s) in which I have elected to participate will be deducted from my salary on a pre-tax basis unless I elect otherwise on a separate form.
☐ I **Decline** to participate in the Flexible Spending Account for the Plan Year. *(If you are declining coverage, omit the rest of this form and sign where indicated.)*

	Annual Election		# Pay Periods		Reduction/Pay
General Purpose Flexible Spending Account Maximum Election $2,750.00	**$** _____	÷	_____	=	**$** _____
Dependent Care Flexible Spending Account Maximum Election $5,000.00/ household	**$** _____	÷	_____	=	**$** _____
Total Salary Reduction / Pay				=	**$** _____

I understand and agree that:

- ✓ I cannot change or revoke any of my election(s) at any time during the plan year unless I have a change in status and my election is consistent with such change.
- ✓ Any amounts of my election(s) that are not used by the end of Plan Year will be forfeited.
- ✓ Claims must be submitted within 90 days of the end of the Plan Year.
- ✓ I agree to provide the plan administrator with substantiating documentation when I seek reimbursement or when supporting documentation is requested.
- ✓ I cannot seek reimbursement from the FSA for an expense which I intend on taking as a deduction or credit on my tax return.
- ✓ I must disclose the name and Tax ID Number of my dependent care provider(s) on my federal income tax form if I participate in the Dependent Care FSA.
- ✓ Any election to receive health care reimbursement and/or dependent care reimbursement will be subject to the additional rules set out in the plan document.

Employee Signature: _____ **Date:** _____

TO BE COMPLETED BY EMPLOYER

Employer's Signature _____ **Date Approved:** ____/____/____

Participant's Effective Date: ____/____/____ **Date of 1st Payroll Deduction:** ____/____/____