Stark County Schools

Flexible Spending Account Election Form

ACCOUNT HOLDER INFORMATION:			
Name:	SSN:	Date of Birth:	
Street Address:	**City:**	**State:**	**Zip Code:**
E-Mail Address:	**District:**		
First Payroll Deduction Date:	**Benefit Effective Date:**		
Payroll Schedule (i.e. Weekly, Bi-Weekly, Bi-Monthly, etc.):			

Regarding my salary redirection agreement and my election of benefits, I understand that:
In accordance with my rights under the plan, I elect the following benefits and designate the following amount for the plan year specified above. The Employer and I agree that my cash compensation will be reduced by the amount set forth below for each pay period and plan year (or during such portion of the year as remains after the date of this agreement).

ANNUAL ELECTION:		
I elect to participate in the Employer sponsored **group medical, dental or vision plan** and understand my contribution will be made on a pre-tax basis:	☐Yes	☐No
I elect to participate in the Employer sponsored **Flex plan** on a pre-tax basis:	☐Yes	☐No

	Amount Per Pay	Annual Amount
Medical Care Reimbursement Account *maximum contribution $2,500*	$	$
Dependent Care Reimbursement Account *maximum contribution $5,000*	$	$

IMPORTANT INFORMATION ABOUT THE DEBIT CARD:
Your flex debit card may be used for immediate payment of eligible medical or dependent care expenses at qualified providers of service that accept FSA debit cards. Remember that debit card transaction receipts must still be saved. A review of electronic transactions may result in a request to provide itemized bills or transaction receipts to substantiate each claim. Failure to provide the necessary documentation may result in the deactivation of your debit card.

Regarding my salary redirection agreement and my election of benefits, I understand that:
AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire Plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my payroll department. I understand that my medical information related to this Plan will be shared with my spouse, dependent, or legal guardian unless I contact the employer otherwise.

Employee's Signature: X ____________________ **Date:** ____________

Emrollment Form Instructions

Client ID and Employer Name: Enter your Client ID and Employer name in the space indicated. Refer to your employer for the correct Client number and Employer name. Make sure to have this information available when calling for enrollment assistance. Check whether this enrollment is for a new (first-time) enrollment or for the renewal of a previous flexible spending account. If this is a mid-year election, calculate only the number of payroll deductions remaining in the year.

1. Medical Expenses: This amount is usually paid per year toward deductible and co-insurance portions of health insurance, dental expenses, orthodontic expenses, eye care and other miscellaneous health care expenses. After determining the payroll amount, multiply that number by the number of payrolls to determine your annual election. Check with your employer for the amount you may deduct.

2. Dependent Day Care: Amount paid for day care expenses per year. The maximum allowable amount under IRS regulations is $5,000 per calendar year per family. This limit holds fast regardless of the number of dependents you may have.