



If you wish to participate in any portion of the flexible benefit plan you must complete the following section. You may elect to participate in one, or any combination of the three benefits out lined below.

Return this completed form to your Benefits Office Representative

SECTION A – EMPLOYEE DATA (PLEASE PRINT OR TYPE)
Name: SSN: Home Phone:
Street Address:
City: State: Zip Code:
DOB (date of birth): Date of Hire: Date of First Contribution (payroll date):
Email:

SECTION B – Dependent Information- Please list your Dependent Information below:
Spouse: DOB: Dependent: DOB:
Dependent: DOB: Dependent: DOB:

SECTION C - I ELECT TO PARTICIPATE IN THE PLAN. I authorize my employer to reduce my salary by the amounts indicated below.
1. COMPANY SPONSORED INSURANCE PREMIUMS (initial) Int.
I understand based on the coverages I have enrolled in, any premium amounts exceeding the District Maximum Contribution will be deducted from my salary and this deduction will be made on a pre-tax basis.
2. MEDICAL REIMBURSEMENT ACCOUNT YES NO
This includes all eligible health related expenses not covered by my health insurance or any other benefit plan for me and my dependents. This account does NOT cover any type of Insurance Premiums.
I elect \$ as my ANNUAL Medical Reimbursement election for 2011-2012.
For office use only \$ Annual Election / remaining pay periods = per paycheck contribution
3. DEPENDENT DAYCARE ACCOUNT YES NO
This account may not exceed \$5,000 if you are single or married and file a joint return, or \$2,500 if you are married and file a separate return. Only dependent children under age 13 (unless physically or mentally handicapped) and/or a dependent adult requiring daycare qualify only for the hours when you and your spouse (if any) are at work.
I elect \$ as my ANNUAL Dependent Care election for 2011-2012.
For office use only \$ Annual Election / remaining pay periods = per paycheck contribution

SECTION E – EMPLOYEE AUTHORIZATION AND SIGNATURE
I understand that:
I cannot change this election during the plan year unless I undergo a change in family status.
Any unused funds left in my account at the end of the plan year are forfeited.
If I terminate my employment, whether voluntarily or involuntarily, and do not elect to COBRA my Medical Reimbursement Account, I can only submit expenses incurred prior to my termination date.
My Social Security Benefits/Disability may be affected by this election.
I cannot claim a tax credit for any expenses paid for by this Plan.
If I elect to participate in the Dependent Daycare Account I must file IRS Form 2441 with my tax return.
This election replaces any prior elections and will terminate at the end of the plan year, or if this plan is terminated.

Date: Employee Signature: