BLOOMINGTON SCHOOL DISTRICT #271
FLEXIBLE SPENDING PLAN ELECTION FORM

PLAN YEAR: July 01 – June 30 **EFFECTIVE DATE:** _____

EMPLOYEE INFORMATION:

Name: Social Security #:

Address: Email:

City: State: Zip: Primary Phone: ( ) -

Date of Birth: Gender: ☐ Male ☐ Female Hours worked per week:

Date of Hire: Work Phone: ( ) -

Flexible Spending Plan – Premium Conversion Account

Includes all employer sponsored premiums paid by payroll deduction - Participation is automatic.

☐ Waive Participation (I do not have an insurance deduction or do not want insurance deductions pre-taxed.)

Flexible Spending Account – Dependent Care

Plan Year Election: $ _____ (Maximum $5,000 per plan year or $2,500 if married but filing separately)
(Limited to $208.33 per pay period deduction)

☐ Waive Participation

ENROLLMENT AUTHORIZATION:

λ I understand the benefit options and requirements presented therein. λ I am enrolling for the eligible benefits I indicate in the COVERAGE section and I authorize reductions from my earnings. λ I understand and agree that if my eligible expenses do not reach the amount I have allocated to that benefit, I will forfeit any amounts remaining in my participant account at the end of the Plan Year. λ I assume this risk of forfeiture of moneys remaining in my flex accounts. λ I also understand that all expenses for which I seek reimbursement must be for services performed during the Plan Year and while I am a participant in the Flexible Spending Plan. λ I understand payments for Reimbursement Accounts will be made directly to me. λ I understand that I cannot revise or revoke this Enrollment Authorization or in any way change the amounts deducted from my salary during the Plan Year, except where the change is consistent with a family status as defined in the Flexible Spending Plan. λ I agree to observe the terms and conditions of the Flexible Benefits Plan and all rules and regulations established by the Company to administer the Plan. λ I understand that the Employer cannot be held responsible for the tax consequences which may or may not result from the benefit(s) I have selected above. λ This plan is regulated by Internal Revenue Code Sections 105 and 129, and is subject to discrimination regulations. λ In the event that the plan is found to be out of compliance with discrimination rules, I may be required to reduce or eliminate my pre-tax deduction election.

PlanSource
PO Box 46040
Plymouth, MN 55447
Phone: (612) 256-0855 Fax: claims@plansource.com

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EMPLOYEE SIGNATURE **DATE**