OSSEO AREA SCHOOLS - ISD 279
FLEXIBLE BENEFITS ELECTION FORM

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

EMPLOYEE INFORMATION: **Employee #:** _____

Name: _____ Contract: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth:_____ Gender: ☐ Male ☐ Female

Social Security #: _____ Primary Phone: _____

Date of Hire:_____ Hours worked per week:_____

Email: _____

FULL MEDICAL FLEXIBLE SPENDING

Plan Year Election: $ _____ (Maximum $2,500 per plan year)

☐ Waive Participation

Group or individual insurance premiums are not an eligible expense under the Health Care Flexible Spending Account.

LIMITED MEDICAL FLEXIBLE SPENDING (VISION AND DENTAL ONLY)

If you are making or receiving contributions to a Health Savings Account (HSA) you are ineligible to participate in the Flexible Spending Account – Health Care option. Instead, you are eligible for the Limited Scope Health Care Reimbursement option, which is limited to reimbursing only dental, vision and preventive care expenses. Other medical expenses can only be reimbursed through your HSA account.

Plan Year Election: $ _____ (Maximum $2,500 per plan year)

☐ Waive Participation

Group or individual insurance premiums are not an eligible expense under the Limited Scope Health Care Reimbursement Account.

I understand that I may be required to provide documentation to substantiate the claim for an expense paid with the debit card and that I must do so within the timeframe stated in the request. In the event that I do not provide the required documentation and fail to repay the unauthorized charge; my employer will deactivate the card and consider the charge a debt to the organization and may deduct the charge from my paycheck.

DEPENDENT CARE FLEXIBLE SPENDING

Plan Year Election: $ _____ (IRS Maximum $5,000 per plan year or $2,500 if married but filing separately)

☐ Waive Participation

ENROLLMENT AUTHORIZATION:

I understand the benefit options and requirements presented therein. I am enrolling for the eligible benefits I indicate in the COVERAGE section and I authorize reductions from my earnings. 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. I assume this risk of forfeiture of moneys remaining in my flex accounts. 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 Benefits Plan. I understand payments for Reimbursement Accounts will be made directly to me. 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 Benefits Plan. 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. 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. This plan is regulated by Internal Revenue Code Sections 105, 125, and 129, and is subject to discrimination regulations. 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. I understand that I may be required to provide documentation to substantiate the claim for an expense paid with the debit card and that I must do so within the timeframe stated in the request. In the event that I do not provide the required documentation and fail to repay the unauthorized charge; my employer will deactivate the card and consider the charge a debt to the organization and may deduct the charge from my paycheck.

PlanSource
701 Xenia Ave S, #150
Minneapolis, MN 55416
Phone: (612) 256-0849 Fax: (407) 386-8937

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EMPLOYEE SIGNATURE **DATE**