LGC NEW HAMPSHIRE
Local Government Center

SAU #29 Keene School District – Paraprofessionals and Speech-Psych

Flexible Benefits Plan – *Enrollment Form*

First Name_____ Last Name_____ MI_____ Gender_____ Date of Birth_____ Marital Status _____

Social Security #_____ Home Telephone_____ Work Telephone_____ E-mail Address_____

Mailing Address_____ City_____ State_____ Zip_____

Premium Conversion (Pre-Tax Payroll Deduction of Insurance Premiums)

I understand by electing this option, my share of the premium under the plan(s) chosen below will be deducted from my paycheck on a **pre-tax** basis. I understand that if I do not elect Premium Conversion, my share of the premium under the plan(s) will be deducted from my paycheck on an **after-tax** basis. I also understand that if my premium obligation increases or decreases during the Plan Year, my salary reduction will be adjusted automatically. The amount(s) of this benefit have been provided in such other plan materials provided by SAU #29 Keene School District.

❑ **I hereby elect to participate in Premium Conversion for the following plans (check all that apply): ❑ Medical ❑ Dental**

Healthcare Flexible Spending Account Election

I understand that by electing this option, my election amount will be deducted from my paycheck on a pre-tax basis in equal installments throughout the plan year, and this account will only reimburse IRS-eligible healthcare expenses that have not been reimbursed under any other plan.

❑ I do ❑ I do not want to participate in the Healthcare Flexible Spending Account. $_____ X _____ = $_____
Per Pay Period Election Amount # of Pay Periods Total Election Amount

Minimum Contribution Amount $ 200 Maximum Contribution Amount $ 1,500

Dependent Care Reimbursement Account Election

I understand that by electing this option, my election amount will be deducted from my paycheck on a pre-tax basis in equal installments throughout the plan year, and this account will only reimburse IRS-eligible dependent care expenses that have not been reimbursed under any other plan. I understand that the IRS requires disclosure of a Tax ID or the Social Security number of my daycare provider on my income tax filing and when applying for reimbursement from my Dependent Care Reimbursement Account.

❑ I do ❑ I do not want to participate in the Dependent Care Reimbursement Account. $_____ X _____ = $_____
Per Pay Period Election Amount # of Pay Periods Total Election Amount

Minimum Contribution Amount $ 200 Maximum Contribution Amount $ 5,000

Salary Reduction Agreement and Signature

I also understand and agree to the following:

- The total amount(s) stated above will be deducted from my paychecks on a pre-tax basis in equal installments throughout the Plan Year. I understand that this will lower my gross pay and, consequently, Social Security earnings for tax purposes.
- I must continue enrollment in the Plan, with my above stated salary reduction amount(s), until the end of the Plan Year or my employment termination date, whichever occurs first. However, in the event of a change in my family or employment status (i.e. marriage, divorce, birth, paid or unpaid leave of absence, change in hours, etc.), I may be allowed to change or revoke my salary reduction amount(s) in accordance with plan rules.
- I will be obligated to re-pay any mistaken payments I receive from the Plan in accordance with the Plan terms.
- IRS regulations stipulate a "use-it-or-lose-it" rule that requires employees to use all of their designated Healthcare FSA or Dependent Care Reimbursement Account funds during the plan year (or during the 2½ month grace period immediately following the plan year if elected by your employer) or forfeit remaining balances.
- My Healthcare Flexible Spending Account will reimburse IRS-eligible healthcare expenses up to my annual election amount (minus any previous payment).
- My Dependent Care Reimbursement Account will reimburse IRS-eligible dependent care expenses only up to my account balance at the time of my request.

Employee Signature _____ **Date** _____

Employer Information

Annual Open Enrollment _____ OR New Hire _____	If New Hire Date of Hire _____ Effective Date _____	Payroll Calendar : 10-month (18 pays) _____