



NH School Administrative Unit 29 – KEENE SECRETARIES
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 my required premium contribution for each plan has been provided to me by my employer in other plan materials.

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

Cash Opt-Out

I understand that by electing this option, I am accepting cash in lieu of participation in the following plans (if offered by my employer group). I understand that this cash benefit is subject to federal income plus FICA and Social Security taxes, and that I won't be eligible to receive benefits under any of the plans for which I elect the cash opt-out. The amount(s) of this cash benefit has been provided to me by my employer in other plan materials.

I hereby elect the Cash Opt-out benefit in lieu of participation in the following plan(s): Medical

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.
- My elections, including any above stated salary reduction amount(s), must remain in effect 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 election(s) and 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-or-lose" 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). I understand that I (or my spouse if applicable) cannot make contributions to a Health Savings Account (HSA) if covered by the Healthcare FSA.

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: 12 months (26 payperiods)
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