



SAU #29 Office
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 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.
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 do I do not want to participate in the Dependent Care Reimbursement Account.
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 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.
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.
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: 12-month (26 pays)