PLAINVIEW-OLD BETHPAGE CSD
FLEXIBLE SPENDING COMPENSATION PLAN
ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT
PERIOD OF COVERAGE – 01/01/2022 THROUGH 12/31/2022

(Please Print)

1. PERSONAL DATA

Name____
(Last) (First) (MI)

Marital Status: __________________ Date of Birth ______________ Soc. Sec. ________ -________ -_________

Address____
(Street) (Apt. #) (City) (State) (Zip)

BLDG. LOC. ______________

Email _______________________________ Work Phone______________ Home/Cell Phone ______________

DEPENDENT INFORMATION (List ALL eligible Dependents Affected by Enrollment- attach additional sheet if necessary)

Last Name	First Name	Relationship (Self/Spouse/Child)	M/F	SS# Last 4 digits	Date of Birth
Employee		*Self*			
Dependent					
Dependent					
Dependent					
Dependent					

Please note, Payroll will automatically deduct on a pretax basis any required contributions you must pay towards health, dental, or excess medical coverage unless otherwise notified in writing prior to the filing date.

2. FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS

( ) **HEALTH FLEXIBLE SPENDING ACCOUNT** –The Benefit Period annual deposit into the Health Care Flexible Spending Account cannot exceed an amount of **$2,850.00 or a minimum of $100.00.**
Annual election amount $_________________ $________________ for each pay period (contribution will be made in equal amounts through payroll deductions).

( ) **DEPENDENT CARE ASSISTANCE PLAN -** The Benefit Period **maximum cannot exceed $5,000.00 ($2,500 for married Participants who file separate returns).**
Annual election amount $_________________ $________________ for each pay period (contribution will be made in equal amounts through payroll deductions).

Qualified expenses incurred during the Benefit Period 01/01/2022-12/31/2022. You have 90 days after the benefit period to file your claim. All claims for expenses incurred from 01/01/2022-12/31/2022 must be postmarked no later than 03/31/2023, or your claim will be denied for late filing.

3. AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event (QLE). I may then revoke my prior election and sign a new Agreement if such a change occurs. QLEs include a change in your legal marital status, birth of a child, date you adopt a child, death of spouse or dependent, loss of employment, or your child reaches the age 13 or change in child care services. Changes must be submitted within 30 days of the qualifying life event (QLE).

I understand that when I submit a claim, I must include appropriate documentation (e.g. explanation of benefits from my Insurance Provider, itemized bill, etc.) for out-of-pocket Medical, Dental, Vision expenses before I can be reimbursed.

I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize **Plainview-Old Bethpage CSD** to make pretax deductions from my salary on the payroll schedule I have elected above.

Employee's Signature ____ Date: ______________