

FLEXIBLE BENEFIT ELECTION FORM
Regional School District #11
Hampton Board of Education

July 1, 2017 to June 30, 2018

The Flexible Benefit Plan allows you to make your contribution toward your benefits with pre-tax dollars. These dollars are not subject to FICA, federal or state income taxes. The plans covered by this agreement are listed in the **Summary Plan Description** and include the Flexible Spending Accounts listed below.

		Annual	Per Pay
Medical Care Flexible Spending Account			
For reimbursement of eligible medical care expenses for you, your IRS-defined spouse & qualified dependents who do not contribute to a Health Savings Account (HSA)			
Maximum:	\$ 2000 per plan year	\$	\$
Minimum:	\$ 200 per plan year		
Limited Purpose Medical Care Flexible Spending Account			
For reimbursement of eligible medical care expenses for you, your IRS-defined spouse & qualified dependents who contribute to a Health Savings Account (HSA)*			
Maximum:	\$ 2000 per plan year	\$	\$
Minimum:	\$ 200 per plan year		
Dependent Care Flexible Spending Account			
For reimbursement of eligible work-related child care or elder care expenses			
Maximum:	\$ 5000 per year <i>Single or Married, filing jointly</i> \$ 2500 per year <i>Married, filing separately</i>	\$	\$

*** My signature below indicates my understanding that if I or my spouse are enrolled in a High Deductible Health Plan and contribute to a Health Savings Account (HSA), my pre-tax Medical Flexible Spending Account dollars are limited to vision, dental or preventive care expenses until I have met the federally mandated amount of deductible expenses.**

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above. I understand this agreement will remain in effect until the end of the plan year unless one of the following events occurs: A change in legal marital status due to marriage, divorce, legal separation, annulment, or my spouse's death; a change in the number of my qualified dependents due to birth, adoption, placement for adoption, or death; a change in employment status for me, my spouse or qualified dependent that affects benefits eligibility, such as termination or commencement of employment, a reduction or increase in hours worked affecting my eligibility, a strike or lockout, commencement of, or return from an unpaid leave of absence, or a change in worksite; an event that causes my qualified dependent to satisfy or cease to satisfy status as a qualified dependent; a change in my, my spouse's or my dependent's residence; special enrollment rights; certain judgments, decrees and orders; entitlement to Medicare or Medicaid; certain changes in cost; and certain changes in coverage. Each of these events is defined in the **Summary Plan Description** and any request for change will be governed by the terms outlined in the Summary Plan Description and the underlying group health plans (when applicable). I further understand that in the event the cost of a non-Flexible Spending Account benefit I have selected changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

Employee Name (please print)		Social Security Number	
Employee Date of Hire	Employee Date of Birth	Email address	
Address	City	State	Zip
Employee Signature		Date	

Human Resources/Payroll please complete: Effective Date: _____ First P/R Date: _____ Payroll Cycle: W B S M

IRS regulations prohibit sole proprietors, LLC members and greater than 2% subchapter S Corp. owners from participating in a flexible benefit plan.