BENEFIT DYNAMICS

Antioch Unified School District

September 2011 – August 2012 Flexible Benefits Plan Enrollment Form

If you wish to participate in any portion of the flexible benefit plan **you must complete the following section.** You may elect to participate in one, or any combination of the three benefits out lined below.

Return this completed form to your Benefits Office Representative

SECTION A – EMPLOYEE DATA (PLEASE PRINT OR TYPE)

Name:	**SSN:**	**Home Phone:**
Street Address:		
City:	**State:**	**Zip Code:**
DOB (date of birth):	**Date of Hire:**	**Date of First Contribution (payroll date):**
Email:		

SECTION B – Dependent Information- Please list your **Dependent Information** below:

Spouse: _____ **DOB:** _____ **Dependent:** _____ **DOB:** _____

Dependent: _____ **DOB**: _____ **Dependent:** _____ **DOB:** _____

SECTION C - I ELECT TO PARTICIPATE IN THE PLAN. I authorize my employer to reduce my salary by the amounts indicated below.

1. COMPANY SPONSORED INSURANCE PREMIUMS *(initial)* _____ **Int.**

I understand based on the coverages I have enrolled in, any premium amounts exceeding the District Maximum Contribution will be deducted from my salary and this deduction will be made on a pre-tax basis.

2. MEDICAL REIMBURSEMENT ACCOUNT ☐ **YES** ☐ **NO**

This includes all eligible health related expenses not covered by my health insurance or any other benefit plan for me and my dependents. *This account does NOT cover any type of Insurance Premiums.*

I elect $_____ as my **ANNUAL** Medical Reimbursement election for 2011-2012.

For office use only $_____ / _____ = _____
Annual Election *remaining pay periods* *per paycheck contribution*

3. DEPENDENT DAYCARE ACCOUNT ☐ **YES** ☐ **NO**

This account may not exceed $5,000 if you are single or married and file a joint return, or $2,500 if you are married and file a separate return. Only dependent children under age 13 (unless physically or mentally handicapped) and/or a dependent adult requiring daycare qualify only for the hours when you and your spouse (if any) are at work.

I elect $_____ as my **ANNUAL** Dependent Care election for 2011-2012.

For office use only $_____ / _____ = _____
Annual Election *remaining pay periods* *per paycheck contribution*

SECTION E – EMPLOYEE AUTHORIZATION AND SIGNATURE

I understand that:

- I cannot change this election during the plan year unless I undergo a change in family status.
- Any unused funds left in my account at the end of the plan year are forfeited.
- If I terminate my employment, whether voluntarily or involuntarily, and do not elect to COBRA my Medical Reimbursement Account, I can only submit expenses incurred prior to my termination date.
- My Social Security Benefits/Disability may be affected by this election.
- I cannot claim a tax credit for any expenses paid for by this Plan.
- If I elect to participate in the Dependent Daycare Account I must file IRS Form 2441 with my tax return.
- This election replaces any prior elections and will terminate at the end of the plan year, or if this plan is terminated.

Date:	**Employee Signature:**