DIXON PUBLIC SCHOOL DISTRICT #170

ENROLLMENT FORM—*Plan Year:* ***January 1, 2012***

FLEXIBLE SPENDING ACCOUNT PLAN

YOUR INFORMATION

Alternate-ID # or
Social Security #:_____ Location:_____

Last Name:_____ First Name:_____

Address:_____ Date of Birth:_____/_____/_____
(Street Name)

_____ Marital Status:_____ Gender:_____
(City) (State) (Zip Code)

HEALTH FSA

$5,000.00 MAXIMUM

MONTHLY PAYROLL:

Annual Maximum $_____

Number of Pay Periods 10

Pay Period Amount $_____

Annual Maximum $_____

Number of Pay Periods 12

Pay Period Amount $_____

SEMI-MONTHLY PAYROLL:

Annual Maximum $_____

Number of Pay Periods 24

Pay Period Amount $_____

AUTOMATIC REIMBURSEMENT OPTION:

I request an automatic reimbursement from my Health Care FSA for all medical deductibles and co-payments calculated by TBB according to the Dixon Public School District #170 Group Insurance Plan for services provided January 1 through December 31, 2012 for myself and/or my family.

I understand that these automatically reimbursed expenses cannot be reimbursed through any other insurance plan or third party.

☐ YES ☐ NO

DEPENDENT CARE FSA

$5,000.00 MAXIMUM

MONTHLY PAYROLL:

Annual Maximum $_____

Number of Pay Periods 10

Pay Period Amount $_____

Annual Maximum $_____

Number of Pay Periods 12

Pay Period Amount $_____

SEMI-MONTHLY PAYROLL:

Annual Maximum $_____

Number of Pay Periods 24

Pay Period Amount $_____

I understand that these elections are irrevocable until January 1, 2013 except in the event of an IRS qualifying event, and any money remaining in the Heath FSA or Dependent Care FSA after the March 31, 2013 claim submittal deadline will be forfeited.

EMPLOYEE SIGNATURE:

_____

DATE: _____

The deadline to submit this enrollment is November 21, 2011.