BASIC

LIMITED PURPOSE FLEXIBLE SPENDING

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION

Employer Name: Davison Community Schools

Participant First Name: _____ Last Name: _____

Social Security #: | | | | - | | | - | | | | | Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

Pay Period: [X] Bi-Weekly (every other week)

Plan Year: January 1, - December 31, 2021

MEDICAL REIMBURSEMENT ACCOUNT – **LIMITED PURPOSE**

☐ I elect to participate (not to exceed employer limit of $2,750)

$_____ per pay x 21 (# of pays in plan year) = $ _____ Annually (do not round)

☐ I elect NOT to participate.

DEPENDENT CARE ACCOUNT

☐ I elect to participate (not to exceed $5,000 or $2,500 if married filing separately)

$_____ per pay x 21 (# of pays in plan year) = $ _____ Annually (do not round)

☐ I elect NOT to participate.

EMPLOYER USE
Please complete for mid-year enrollments.
Date of first deduction

Eligibility Date:

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____