New Hope - Solebury School District Enrollment Form

Plan Year: 2018 (7/1/2018 - 6/30/2019) BAS-Key: 0000633-0000-000--XXXXXX--I
Benefits Class: Benefits Eligible

Employee Profile Data

Please make any necessary corrections on this form.

Employee's Name		Gender		Soc. Sec. #		Date of Hire	
Address Line 1				Date of Birth		Eligible Date	
Address Line 2				Home Phone #		Dept. No.	
City	State	Zip		Full/Part-Time			

Your Available Flexible Spending Accounts

Please fill in indicator circles next to each coverage in which you would like to enroll.
Note: Enter your Annual Election Amount for each selected coverage.

Healthcare FSA (Optional)

☐ **WAIVE**

If you elect this coverage, then a pro rata portion of your annual election will be deducted from each remaining pay periods in the plan year 2018.

◯ Elect coverage - Write in the amount of your Plan Year Election = $_____ The maximum election for 7/1/2018 - 6/30/2019 is $2,650.00

Dependent FSA (Optional) *

☐ **WAIVE**

If you elect this coverage, then a pro rata portion of your annual election will be deducted from each remaining pay periods in the plan year 2018.

◯ Elect coverage - Write in the amount of your Plan Year Election = $_____ The maximum election for 7/1/2018 - 6/30/2019 is $5,000.00 *

* If you are married and file a separate tax return from your spouse, then the maximum contribution is $2,500.00

Dependent Listing

Dependents Full Name (last, first, mi.)	Relationship (i.e., Spouse, Child)	Date of Birth (mm/dd/yyyy)	Soc. Sec. #	Gender (M/F)	Full-Time Student (Yes/No)	Handi-capped (Yes/No)	Remove Date

Dependents Separate Legal Home Addresses

Do any of the dependents listed above live at a legal home address different from employee's home address? ◯ Yes ◯ No

If Yes, then please provide the following information:

Who?
What Address?
Explain Circumstances:
If any dependent's last name is different from employee's, please explain why:

Authorization

I hereby elect the amounts I have recorded on this form to be reduced from my gross paycheck. I recognize that my contributions through payroll reduction are completely voluntary and in compliance with State Law. I understand that I cannot change my elections until the next plan year unless I experience a qualified status change event as described in the informational materials, at which time I must notify my employer within 30 days, if I wish to change my elections. Furthermore, in the event I separate from service with my employer, I understand my employer will withhold a portion of wages from my final paycheck(s), in an amount equal to the withholding assessed each pay period, in accordance with my election(s) described in this salary reduction agreement.

By selecting a Health Care Flexible Spending Account, I understand that any amounts not claimed from this account during the plan year will be forfeited.

By selecting a Dependent/Elder Care Flexible Spending Account, I certify that my dependent day care expenses do not exceed the lower of my or my spouse's income. Furthermore, I understand that any amounts not claimed from this account during the plan year will be forfeited.

Employee's Signature: _____ **Date:** _____

Payroll Schedule Selection - Employer's Use Only

Employer must select one of the following payroll schedules on employee's behalf.

◯ 26 pays 1st Pay Date: Fri - Jul 6, 2018
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