New Hope - Solebury School District Enrollment Form

Plan Year: 2019 (7/1/2019 - 6/30/2020) BAS-Key: 0000633-0000-000
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 2019.

◯ Elect coverage - Write in the amount of your Plan Year Election = $_____ The maximum election for 7/1/2019 - 6/30/2020 is $2,700.00

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 2019.

◯ Elect coverage - Write in the amount of your Plan Year Election = $_____ The maximum election for 7/1/2019 - 6/30/2020 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
List Additional Dependents Below (Attach a sheet of paper to list additional dependents, if more space is needed)							

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 w thin 30 days, if I wish to change my elections. Furthermore, in the event I separate from service with my employer, I understand my employer w ill withhold a portion of w ages 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 w ill 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 w ill 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.

◯ 22 Pays – 10 Month Support Staff
◯ 22 Pays – Teachers Only
◯ 26 pays- 12-Month Support/Administrative Staff
◯ 26 pays - Teachers