SHELBYVILLE CENTRAL SCHOOL CORPORATION
FLEXIBLE BENEFITS PLAN

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

_____
Name (please print)

Address:_____

City, State, Zip _____

Social Security Number _____

Location _____ Job Classification_____

Please reduce my earnings for 2023 sufficient to fund the following Flexible Spending Account(s):

Unreimbursed Medical Account $_____
(Maximum: $3,050 per year)

Dependent Care Assistance Account $_____
(Maximum: $5,000 per year)

I authorize the company to reduce my annual earnings by the amounts indicated for the Flexible Spending Account(s) listed above. This reduction will take the form of payroll deductions from my regular paychecks, when those paychecks are sufficient to permit a deduction. If my pay in any pay period is insufficient to allow a full deduction, a partial deduction may be made.

I realize that this authorization is irrevocable, and that I will be allowed to change the amount deducted only if there is a change in my family circumstances, specifically, the gain or loss of a dependent or my spouse's loss or change of employment.

I realize that any amount remaining in my Flexible Spending Account(s) after I have been reimbursed for eligible expenses incurred in 2023 will be forfeited.

Signed: _____

Date:_____