St. Charles CUSD #303

Flexible Spending Account (FSA) Enrollment Form

SECTION 1 | Type of Flexible Spending Account

I wish to enroll in the following for 2020 (check all that apply).

☐ **Healthcare FSA** ☐ **Dependent Care Account**

SECTION 2 | Employee Information

First Name	M.I.	Last Name		Social Security Number		Phone Number
Address			Date of Birth	City	State	Zip

SECTION 3 | Calculate Your Per Pay Contributions to Your Healthcare FSA

	Healthcare FSA
1. Annual Election (cannot exceed $2,700 for 2020)	
2. Number of pay periods per year (19, 20, 21 or 24)	
3. Election per pay period (divide line 1 by line 2)	

SECTION 4 | Calculate Your Per Pay Contributions to Your Dependent Care Account

	Dependent Care Account
1. Annual Election (cannot exceed $5,000, or $2,500 if married but filing separate tax returns)	
2. Number of pay periods per year (19, 20, 21 or 24)	
3. Election per pay period (divide line 2 by line 3)	

SECTION 5 | Authorization *(required)*

- By signing this form, I am requesting that payroll deductions be started as shown in Section 3 and/or Section 4.
- I understand that my elections are based on the eligible expenses allowed by the IRS. Any expense that I have included that is not eligible for reimbursement, will not be paid; any question on eligibility will be determined by my employer.
- I understand that I cannot contribute to a medical FSA and an HSA (mine or my spouse's) in the same year.
- I have reviewed the above elections and understand my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS.
- It is my understanding that funds exceeding the applicable carryover amount remaining in my accounts at the end of the Plan Year may be forfeited.

Employee Signature	
Print Name	Date

Return this form to Alexia Montavon, Benefits Coordinator. Keep a copy for your records.