WARREN WOODS PUBLIC SCHOOL DISTRICT
FLEXIBLE SPENDING ACCOUNT AND LIMITED PURPOSE FSA

GROUP RESOURCES®
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REIMBURSEMENT ACCOUNT ELECTION FORM

Plan Year July 1, 2024-June 30, 2025

Employee Name: _____ Employee Number_____
(Please Print)

Social Security Number_____ Date of Birth_____/_____/_____

Gender: Male/Female Email address: _____
Please Circle

Address: _____
Street City State Zip

Please Circle
Do you want to use the debit card service for 2024-2025? Yes No

REIMBURSEMENT ACCOUNTS Effective Date: _____
(For Office Use Only)

	Reduction Per Pay	Annual Amount	
A. Uninsured Health Care	$_____	$_____	($3,200 Max $60 Min)
B. Dependent Care	$_____	$_____	($5,000 Max $60 Min)
C. Limited Purpose FSA	$_____	$_____	($3,200 Max $60 Min)

I UNDERSTAND THAT I CANNOT CHANGE MY ELECTION AND PAY REDUCTIONS UNLESS I EXPERIENCE A CHANGE IN MY FAMILY STATUS. My employer and I agree that my salary will be reduced by the amount(s) listed above for the benefit option(s) I have elected under the Flexible Spending Plan. I hereby acknowledge that I have read the Understanding of Agreements on the reverse side of this form.

Further, I hereby consent to the use of my personally identifiable information, and or my dependent(s)' information, which I have voluntarily provided on this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, or my dependents' behalf, for the sole use of providing benefits, services, or any information I have requested.

This agreement is subject to the terms of the Warren Woods Schools Flexible Compensation Plan, as amended from time to tome, and revokes any prior election and compensation reduction agreement relating to such plan.

_____ Date _____
Employee Signature

_____ Date_____
Employer Signature

Number of Pays _____ PLEASE SUBMIT ORIGINAL TO ADMINISTRATION OFFICE

UNDERSTANDING OF AGREEMENTS

I have received the printed material explaining the Plan and my options under the Plan, and, I understand that by signing this form, I am making an election which may not be changed for this Plan year other than as permitted by law and the Plan.

I understand that by electing to be covered under the applicable Employer's insurance plan(s), my portion of the premium is automatically reduced from pre-tax wages under the Flexible Compensation Plan, if applicable. Further, I understand that if I do not incur expenses this Plan Year in the amount which I have elected for each benefit, the Plan has for 2024-2025 Plan Year to allow $640.00 carryover rule.

I authorize the reduction of these amounts from my paychecks and acknowledge that these amounts are to be credited to my Flexible Compensation accounts. I authorize the Administrator to draw upon my accounts to reimburse me for eligible expenses incurred by me during the Plan Year. I understand that requests for reimbursement from the reimbursement plan(s) will only be processed if I comply with the terms and conditions of the applicable plan. I also understand that the Plan Administrator and Third Party Claims Administrator may establish rules and procedures from time to time, which also govern processing reimbursement requests. In addition, the Plan Administrator may establish rules and procedures regarding payment of remaining reimbursement contributions upon termination of employment in accordance with the applicable Flexible Benefit Plan Document(s). The Employer and Plan Administrator may take appropriate legal action to assure that reimbursements are made in accordance with the terms and conditions of the reimbursement plan(s).

DEPENDENT CARE

I understand that, for this Plan Year, I may be reimbursed for dependent care expenses up to the maximum of (1) Five Thousand Dollars ($5000) (Two Thousand Five Hundred Dollars ($2500) if married filing separate), (2) my spouse's earnings, if applicable, or (3) 50% of my earnings, whichever is least. I also understand that in order to receive reimbursement, I must submit receipts or other evidence that indicate who was cared for, dates of service, the actual amount paid along with the name, address and social security/tax identification number or the provider of these services. I understand that I or my spouse, if applicable, may not elect to receive the tax credit for the dependent care expenses that I have been reimbursed for under the Plan.

HEALTH CARE EXPENSES

I understand that, for this Plan Year, I may be reimbursed for expenses incurred for my medical care and the medical care of my spouse and dependents which are not covered by medical insurance or other plans up to the maximum amount deemed by the Plan. The "dependent" relationship must exist when the charges were incurred. If I claim reimbursement for these expenses under the Plan, the amount of the reimbursement will be tax free.

Eligible medical expenses include any expenses incurred for diagnosis, cure, treatment, mitigation, or prevention of disease, or for the purpose of affecting any bodily function or structure, prescription drugs or insulin.

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