FLEXIBLE SPENDING PLAN PARTICIPATION FORM

Advantage Administrators (Plan Administrator)

Mount Vernon Community School District

See how flexible spending saves you money: http://www.advantageadmin.com/

Employee Name_______________________________________
Address, City, State, Zip____
Has your home address changed in the last 12 months? Yes ▭ No ▭
Home Phone (____)_______________ Email_____________________________________

Plan year starts 09/01/17 and ends 08/31/18
First payroll start date 09/20/17 Pay Cycle - Monthly

OPTION 1 – Healthcare Flexible Spending Account Agreement

- ☐ I elect to contribute $____________ for the Plan Year (Maximum $2,592), which is $__________ per monthly pay period to fund my account that pays qualified out-of-pocket healthcare expenses not covered by my health and other insurance plans. Your annual amount must be divisible by 12 and be a whole number.

OPTION 2 – Dependent Care Benefit Account

- ☐ I elect to contribute $___________ for the Plan year (Maximum $4,992), which is $__________ per monthly pay period to fund my account that pays qualified dependent care expenses. Your annual amount must be divisible by 12 and be a whole number.

Direct Deposit. You can have your Flexible Spending reimbursements directly deposited into your bank account and receive an email alerting you to this direct deposit. If you used the direct deposit option last year and your bank account information is the same, it will continue this year.

- ☐ If you did not use the direct deposit option last year but would like to use it this year, check this box and attach a voided check or deposit slip.
- ☐ **If you used the direct deposit option last year but your bank account information has changed, check this box and attach a voided check or deposit slip**.
- ☐ Checking account
- ☐ Savings account

My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may only change my election in the event of certain changes in my status and that prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read and understand the Summary Plan Description. I understand that all unused amounts at the end of the plan year will be forfeited to the employer.

Employee Signature ___________________________ Date ____________________