USBAFLEX

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BENEFIT ELECTION FORM

EMPLOYER San Juan School District

Employee Information:

Please print- First, Middle, Last:			Social Security Number:
Employee Home Address:	City:	State:	Zip Code:
E-mail Address:	Hire Date(new employees only):	Pay Schedule: ☐ 10 month ☐ 11 month ☐ 12 month ☐ Other: _____	

FSA / HSA Payroll Deduction:

Medical/Health Care Election-FSA - Employee and dependent's out-of-pocket medical, dental and vision expenses	$_____ **PER PAY PERIOD**	☐ Check here only if participating in a HSA. Medical FSA will be Limited Purpose, covering dental and vision expenses only. (Enter HSA contribution amount below)
Dependent Care Election-FSA - Child or dependent care expenses (ex. day care)	$_____ **PER PAY PERIOD**	$5000 annual maximum for single and married filing jointly, $2500 annual maximum for married filing separately
Health Savings Account-HSA - The monthly contribution amount may not exceed 1/12 of the annual deductable plus any Catch-Up contributions allowed.	$_____ **PER PAY PERIOD**	Annual maximums: 2011- self only $3050, family $6150, 2012- self only $3100, family $6250 Catch-up for age 55 and older add'l $1000

Reimbursement Method:

Contact your employer for availability. If left blank, checks will be issued.

☐ **AxisPlus Debit Card** – Complete the AxisPlus Card Enrollment Agreement

☐ **ACH Direct Deposit** – Complete the Employee Direct Deposit Authorization Form

Salary Reduction Authorization and Acknowledgement:

I understand that pretax deductions to my Health and/or Dependent Care FSA can only be used to reimburse eligible expenses and that any remaining funds at the end of the plan year will be forfeited. This election form will remain in effect and cannot be revoked or changed during the plan year, unless consistent with the qualifying events allowed under this Plan. I have read the Summary Plan Description (SPD) provided to me by my employer.

Heath Savings Accounts- I certify that I am an "Eligible Individual" as defined by the Code and do herby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I further understand that I am responsible for all contributions made to my HSA.

My Social Security may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll reductions as contributions to my Flexible Spending Accounts, Health Savings Account and/or Premium Only Account as indicated above.

Please see your employer or HR contact for administration fee rates, if applicable.

To Authorize Participation: I hereby certify the above information to be correct and true and choose to participate.

Signature _____ Date _____

Please see reverse side for POP (Premium Only Plan) deductions or to decline participation.

Premium Only Account Payroll Deduction:

I elect to participate in the Premium Only account for the upcoming plan period.

Group Medical Insurance Premium- $_____

Group Dental Insurance Premium- $_____

Other_____ $_____

Deductions are per pay period (i.e., monthly, bi-weekly, annually)

Total Premium Deduction- $_____

Salary Reduction Authorization and Acknowledgement on front page.

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose not to participate.

Signature _____ Date _____