BASIC

FLEXIBLE SPENDING ACCOUNT (FSA)

Employer Name: Davison Community Schools

Participant First Name: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

Pay Period: [X] Bi-Weekly (every other week)

Plan Year: January 1, - December 31, 2024

There will be 21 FSA/DCA payroll deductions in the plan year.

EMPLOYER USE
For mid-year enrollments.

Date of first deduction:

Eligibility Date:

MEDICAL REIMBURSEMENT ACCOUNT – **LIMITED PURPOSE for HSA eligibility (dental/vision only)**

[ ] I elect to participate (not to exceed employer limit of $3,050)
$_____ per pay x 21 = $ _____ Annually **(do NOT round this number!)**

[ ] I elect NOT to participate.

DEPENDENT CARE ACCOUNT

[ ] I elect to participate (not to exceed $5,000 or $2,500 if married filing separately)

$_____ per pay x 21 = $ _____ Annually **(do NOT round this number!)**

[ ] I elect NOT to participate.

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Plan Document. I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the plan document. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____