

BASIC

LIMITED PURPOSE FLEXIBLE SPENDING

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION

Employer Name: Davison Community Schools

Participant First Name: _____ Last Name: _____

Social Security #:

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 Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

Pay Period: Bi-Weekly (every other week)

Plan Year: January 1, - December 31, 2020

MEDICAL REIMBURSEMENT ACCOUNT – LIMITED PURPOSE

I elect to participate (not to exceed employer limit of \$2,700)

\$ _____ per pay x 21 (# of pays in plan year) = \$ _____ Annually (do not round)

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 (# of pays in plan year) = \$ _____ Annually (do not round)

I elect NOT to participate.

<p style="text-align: center;">EMPLOYER USE Please complete for mid-year enrollments. Date of first deduction</p> <p style="text-align: center;">Eligibility Date:</p>

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 Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. 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 _____