

**ST. LAWRENCE-LEWIS COUNTIES
SCHOOL DISTRICT EMPLOYEES FLEXIBLE SPENDING PLAN
“STLL FLEX”**

ENROLLMENT FORM

Employee Name:

Address:

Social Security #:

School District:

MADRID-WADDINGTON CENTRAL SCHOOL

Plan Year:

SEPTEMBER 1ST THROUGH AUGUST 31ST

PART I NON-REIMBURSED MEDICAL EXPENSE ACCOUNT

I authorize Madrid-Waddington CSD to deduct from each paycheck the amount identified below as “Amount of Annual Election” divided by the number of pay periods and deposit that sum into my StLL Flex Plan Non-Reimbursed Medical Expense Account. The maximum annual allowable withhold is \$3,000, the minimum annual allowable withhold is \$300 per account.

Amount of Annual Election:

YES NO

I elect to have reimbursements for any deductibles or co-insurance automatically forwarded to me without the submission of a Flex Plan Claim Form. These reimbursements would be based on the information supplied on the Claim Form filed under the Medical Plan. Flex Plan Claim Forms would have to be submitted for any Flex Plan medical expenses other than deductibles or co-insurance.

PART II DEPENDENT CARE REIMBURSEMENT ACCOUNT

I authorize Madrid-Waddington CSD to deduct from each paycheck the amount identified below as “Amount of Annual Election:” divided by the number of pay periods and deposit that sum into my StLL Flex Plan Dependent Care Reimbursement Account. The maximum annual allowable withhold is \$5,000.

Amount of Annual Election:

List information for all dependents you want covered under the plan.

Name	Sex	Birth Date	Relationship	Social Security #

PART III INDIVIDUAL PREMIUM REIMBURSEMENT ACCOUNT

I authorize Madrid-Waddington CSD to deduct from each paycheck the amount identified below as "Amount of Annual Election:" divided by the number of pay periods and deposit that sum into my StLL Flex Plan Individual Premium Reimbursement Account. The maximum annual allowable withhold is \$10,000.

Amount of Annual Election:

PART IV ADOPTION ASSISTANCE REIMBURSEMENT ACCOUNT

I authorize Madrid-Waddington CSD to deduct from each paycheck the amount identified below as "Amount of Annual Election:" divided by the number of pay periods and deposit that sum into my StLL Flex Plan Adoption Assistance Reimbursement Account. The maximum amount of reimbursement for any one child is \$10,960 (this \$10,960 will be adjusted for inflation in years after 2006). This is a total per child rather than an annual amount, even if the expenses occur over a period of years.

Amount of Election:

PART V CERTIFICATION STATEMENT

I hereby authorize my employer to reduce my annual earnings by the amount and for the purpose indicated in the aforementioned Parts I, II, III and IV for the Plan Year beginning September 1st through August 31st. I understand and agree as follows:

1. This amount will be deducted from my regular paychecks. This reduction in my pay will be in addition to any other reductions under other agreements or benefit plans.
2. I may not change or stop my deposits to this account during the Plan Year unless my family status changes, and then only changes consistent with the effect of the change in family status will be permitted. Prior to the first day of each subsequent Plan Year, I will be given the opportunity to change my benefit elections for that Plan Year.
3. In accordance with IRS regulations, I will forfeit any unused balance remaining in my account as of the end of the Plan Year after expenses for the Plan Year have been paid out. I understand I have 90 days following the end of the Plan Year to submit expenses for that year.
4. If my pay for any period is insufficient to cover a deduction, a partial deduction will be made.
5. I can be reimbursed only for qualified expenses incurred during the Plan Year (September 1st through August 31st), or until participation ends.
6. In the event that I terminate employment and end participation and my full annual amount has not been funded, such amounts may be withheld from my final pay, including my vacation pay.
7. This Agreement is subject to the terms and conditions of the Plan, as detailed in the Plan Document, which is on file in the district business office.
8. My signature on this form indicates that I certify to the best of my knowledge that the information on this form is accurate; and that I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.

Signature: _____

Date: _____