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Flexible Spending Account Enrollment Form

Section I. Employer/Employee Information PLEASE PRINT

Employer Name:	Group Number:	Employer Location (if applicable):
Mannheim School District 83	A05100	

Employee Name:	Sex:	Employee SSN:	Date of Birth:	Flex Plan Year:

Address:	City:	State:	Zip:

Employee E-mail Address:	Daytime Phone:

Section II. Election(s)

Use the table below to select your Flex benefits.

	Annual / Mid-Year election pledge	Divided by	# of pay periods of the: annually (Plan Year) / Mid-Year	Equals	Deduction from each pay period
I elect to participate in the Health Flexible Spending Account	$	/		=	$
I elect to participate in the Dependent Care Assistance	$	/		=	$
(Plan Year Example)	$ 2,550.00	/	24	=	Example $106.25

Section III. Allied Flex Debit Card SSN and DOB are required. Dependent must be over 17.

Please complete the information below for all dependents who should have an Allied Flex Debit Card

	Date of Birth:	SSN:	
Spouse Name:			☐ Keep current dependent card active. ☐ Request new dependent debit card.
Dependent Name:			☐ Keep current dependent card active. ☐ Request new dependent debit card.
Dependent Name:			☐ Keep current dependent card active. ☐ Request new dependent debit card.

Section IV. Direct Deposit

I would like to participate in Direct Deposit ☐ Yes ☐ No

If yes, please complete the attached "Flex Direct Deposit Enrollment Form" and include a voided check.

☐ I am currently participating in direct deposit. Please keep current banking information on file.

Section V. Participant Certification

I certify the above information is true and correct and I authorize any premiums and HSA contributions, if applicable, to be paid on a pre-tax basis pursuant to Internal Revenue Code Section 125. I understand that any amounts which are not used for eligible expenses incurred during the Plan Year or Grace Period, will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the salary reduction(s) will be in effect for the Plan Year and cannot be revoked except as authorized by current Plan provisions and laws.

Employee Signature:	Date:

IF YOU DECLINE PARTICIPATION: The benefits of the Plan have been thoroughly explained to me and I decline participation.

Employee Signature:	Date:

Employer Use Only (Required for processing)

Employee's Flex Plan Effective Date	First Payroll Date	Payroll Cycle	I agree this form is correctly filled out by the Employee.
			HR Signature: