

2020 FLEXIBLE SPENDING ACCOUNT ELECTION FORM

Last Name: _____ **First Name:** _____ **Employee ID#:** _____

Address: _____ **Phone:** () _____

City: _____ **State:** _____ **Zip:** _____

HEALTH CARE FSA -- \$2,700 Annual maximum per employee

I wish to redirect a total of \$_____ for the 2020 plan year (\$_____ per pay period, **excluding the July and August pay periods**) to my Health Care FSA.

DEPENDENT CARE FSA -- \$5,000 Annual maximum per family (\$2,500 maximum if married filing separately)

I wish to redirect a total of \$_____ for the 2020 plan year (\$_____ per pay period, **excluding the July and August pay periods**) to my Dependent Care FSA. I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, the annual maximum is \$2,500.

FLEX DEBIT CARD (for Health FSA only) -- I am interested in receiving a Flex Debit Card.

By checking this box, I understand that American Fidelity will send me a Flex Debit Card. Flex debit cards can also be requested for spouse and dependents over the age of 18. To request additional debit cards for eligible dependents, please contact American Fidelity directly at flex@americanfidelity.com or call 800.662.1113.

Authorization — *Please Read Carefully*

I request and authorize the District to reduce the amount of salary payments due me by the above amount(s) and to divert the amount(s) of such reduction(s) to my FSA account(s). I agree that the District shall in no way be liable to me or my successors for any monetary damages which might arise from the federal or state tax consequences of my participation in this plan and consistent therewith. I further agree to save and hold harmless the District from any such monetary damages.

I understand that a reimbursable expense cannot be claimed under both an FSA and any Health Reimbursement Account (HRA) offered by the district. I understand that the choices I have indicated above must remain in effect for the entire 2020 plan year unless I have an eligible family status change. Eligible family status changes include: change in employee's legal marital status; change in the number of tax dependents; termination or commencement of employment by employee, spouse or dependent; change in work schedule (summer recess and intersession periods are not considered family status changes); dependent satisfies (or ceases to satisfy) dependent eligibility requirements; change in residence or worksite of employee, spouse, or dependent.

I understand that any unused balances in either the Health Care or Dependent Care account at the end of the plan year will be forfeited.

Signature of Employee

Date

FOR DISTRICT USE ONLY: Coverage Effective Date: 01/01/2020 No. of Pay Periods:10

PLEASE RETURN TO:

**EMPLOYEE BENEFITS DEPARTMENT
Eugene Brucker Education Center
Room 1150-A**

Originals are not needed. Completed form may
be sent to: **employeebenefits@sandi.net**