StirlingBenefits
Evolving the Business of Benefits

NORWALK PUBLIC SCHOOLS
DEBIT CARD – HEALTH CARE AND DEPENDENT CARE
ELECTION OF BENEFITS & SALARY REDUCTION AGREEMENT

EMPLOYEE NAME (PRINT): _____ EFFECTIVE DATE: _____

EFFECTIVE DATE: _____ SOCIAL SECURITY #:_____

ADDRESS: _____ DATE OF BIRTH: _____ GENDER: _____

EMAIL ADDRESS: _____

FAMILY MEMBERS: Spouse's Name: _____ Date of Birth: _____

Dependent _____ SSN#: _____ Date of Birth: _____
Dependent _____ SSN#: _____ Date of Birth: _____
Dependent _____ SSN#: _____ Date of Birth: _____

I hereby make the following election regarding the benefits made available to me under Norwalk Public Schools Flexible Benefits Plan for the January 1, 2019 to December 31, 2019 plan. **Expenses must be incurred 1/1/19 – 12/31/19 and submitted to the Stirling Benefits office no later than March 31, 2020.**
****Up to $500 remaining in your FSA or LPF account as of December 31, 2019 is eligible for carryover to the next plan year ****
I agree to have my annual, taxable, compensation reduced by an amount equal to the total value of the benefits specified below; such annual amount to be deducted in approximately equal sums from my regular paychecks during the Plan Year on a pre-tax basis.

I further recognize that the reduction in my taxable compensation will remain in effect for the entire Plan, and that such election may be changed only upon the occurrence of a "life event", such as termination of employment or change to part-time status by either myself or my spouse, marriage; divorce, death of an immediate family member; birth or adoption of a child; or significant change in premiums or benefits of the health coverage maintained through my employer, or by my spouse through his or her employer.

ELECTION OF BENEFITS

Reimbursement Sections:	**Annual Election**		**# of Pays**		**FSA Deduction Per Pay**
HEALTH CARE ACCOUNT: **(Minimum - $100 / Maximum - $2,700)**	_____	÷	_____	=	_____
DEPENDENT (Day) CARE ACCOUNT: **(Minimum - $100 / Maximum - $5,000)**	_____	÷	_____	=	_____

Effective January 1, 2011, Over-The-Counter drugs or medicines not prescribed by a doctor will no longer be reimbursable under an FSA program

If you, or your employer on your behalf, actively contribute to an HSA account, or your spouse contributes to an HSA, you may not participate in the Health Care Account.

YES, I want to enroll. The IRS regulation states four conditions. **1.)** Any expenses you incur must be within the plan year. **2.)** Any expenses you incur must not be covered by any other source such as insurance. **3.)** You must provide proper documentation in order to receive payment. **4.)** You cannot change or revoke your elections during the plan year unless there is a specific change of status and your employer allows such changes. Please see the Summary Plan Description. ***NOTE:*** Enrolling may have a minor effect on your social security benefits. Please seek appropriate advice.

Teachers are required to pay the $5.95 monthly administrative fees for the Program
The annual fee of $71.40 will be calculated and deducted pre-tax from each payroll by the Norwalk Public School Payroll Department

Signature: X_____ Date: _____

For Norwalk P.S. Office Use Only _____ (Annual Election) + $71.40 (Fees) = _____ ÷ _____ (# Payrolls) = _____ **Per Pay FSA/Fee Deduction**

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WAIVER OF PARTICIPATION

I acknowledge that I have been given the opportunity to participate in Norwalk Public Schools Flexible Benefits Plan. **However, I have chosen not to participate, as noted below, at this time.** By waiving participation, I realize that I will not again become eligible to participate unless I have a qualified "life event", or until the next Plan Anniversary Date.

Signature _____ Date: _____, 20 ____

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ADMINISTRATIVE SECTION **(Human Resources Department only)**
Deduction/Pay: $_____(Health Care) $_____(Dependent Care) No. Pay Periods: _____

FLEX Account Eff. Date:_____ Election confirmed by:_____ Date: _____