



One Dodge Street
 North Greenbush, NY 12198
 (518) 283-8500

FLEXIBLE SPENDING ACCOUNT

EMPLOYEE/EMPLOYER ELECTION FORM/COMPENSATION REDUCTION AGREEMENT

Flexible Spending Plan Year: July 1, 2016 through June 30, 2017 Enrollment: Month of May

COMPANY/CLIENT NAME		
SOUTH COLONIE CSD		
EMPLOYEE NAME	DATE OF BIRTH / /	DATE OF HIRE-OFFICE USE / /
SOCIAL SECURITY NUMBER	EMPLOYEE PHONE NUMBER	
ADDRESS: STREET, CITY, STATE, ZIP		
EMAIL ADDRESS (REQUIRED)		

ELECTION:

First payroll date _____ (Employer - Office Use Only)

Per Health Care Reform, effective January 1, 2011 over the counter medications will no longer be an eligible FSA item if not accompanied by a prescription.

Unreimbursed Medical Expense Account

I elect to make contributions to a medical reimbursement account for this plan year as follows:

Yearly compensation reduction: \$ _____
 The annual plan limit is \$2,550 per participant.

For Office Use Only
 # of Pay Periods Per Pay Period
 / _____ = \$ _____

Qualifying Medical Care Expenses

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your Federal income tax return with certain exceptions (i.e., health insurance provided by a spouse's employer cannot be reimbursed).

Dependent Care Assistance Account

I elect to make contributions to a dependent care assistance account for this plan year as follows:

Yearly compensation reduction: \$ _____
 (Up to \$5,000 or \$2,500 if married filing separate tax returns)

For Office Use Only
 # of Pay Periods Per Pay Period
 / _____ = \$ _____

Please mail completed form to: South Colonie CSD

Attn: Payroll Department

* In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.

DEPENDENT ENROLLMENT

Dependent Name	Date of Birth	SSN	Relationship



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I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning 07/01/2016 and ending 06/30/2017. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked and I understand that election is required annually to participate. As a participant, I understand that:

- I cannot change or revoke this agreement at any date prior to the next plan year, unless I have a change in my family status as set forth in the Adoption Agreement and Summary Plan Description. Prior to my next Plan Year I will be offered the opportunity to change my benefit election for the following year.
- My pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected, continuing for each scheduled pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that change.
- The Plan Administrator may change the amount of my reduction or otherwise modify this agreement, if he believes it is required to satisfy provisions of the Internal Revenue Code.
- The amount of my compensation reduction will be credited to the appropriate reimbursement account on my employer's books for payment of eligible expenses incurred within the plan year.
- Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount. However, for Health FSAs there is a \$500 carryover provision for unused funds as set forth in the Adoption Agreement and Summary Plan Description.
- All qualifying expenses must be submitted for reimbursement within 90 days from the end of the plan year as set forth in the Adoption Agreement and Summary Plan Description.

PLEASE NOTE:
 The pay reductions will not be effective for any pay period that begins before you have signed this form and returned it to your Employer. Please keep a copy of this form for your records.

CHANGES/TERMINATIONS (Employer – Office Use Only)

Date of Event: ___/___/___
 First paycheck date that change will be processed: ___/___/___.

___ Marriage/Divorce
 ___ Birth/Death of Spouse or Dependent
 ___ Spouse's employment commenced/terminated
 ___ Status change from full-time to part-time or part-time to full-time by employee or spouse
 ___ Unpaid leave of absence by employee or spouse
 ___ Open Enrollment
 ___ Employment Termination

Employee Signature _____ Date _____
 Employer Signature _____ Date _____

HUMAN RESOURCES – OFFICE USE ONLY
(ALL FIELDS REQUIRED)

Highly Compensated <input type="checkbox"/> Y <input type="checkbox"/> N	Spouse or Dependent of Owner <input type="checkbox"/> Y <input type="checkbox"/> N
Key Employee <input type="checkbox"/> Y <input type="checkbox"/> N	More than 5% Owner <input type="checkbox"/> Y <input type="checkbox"/> N
Officer <input type="checkbox"/> Y <input type="checkbox"/> N	More than 1% owner with salary greater than \$150,000 <input type="checkbox"/> Y <input type="checkbox"/> N