POUGHKEEPSIE CITY SCHOOL DISTRICT
FLEXIBLE COMPENSATION PLAN
ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT
Period 1/1/2019 to 12/31/2019

1. PERSONAL DATA-(Please Print)

Name_____
(Last) (First) (Ml)

Marital Status: _____ Soc. Sec. _____ - _____ -_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

Email _____ Work Phone_____ Home/Cell Phone _____

A. FLEXIBLE SPENDING ACCOUNTS

1. HEALTH REIMBURSEMENT ACCOUNT (Health related expenses for Employee & Dependents)

( ) I hereby elect to make the following annual contribution to my Health Care Flexible Spending Account under the Plan and hereby agree that the annual contribution will be made in equal amounts each pay period through payroll deduction:

$___ total for the plan year ___ 20 payments (10 month employees) ____24 payments (12 month employees) $_____ for each pay period.

Note: The annual deposit in the Health Care Flexible Spending Account cannot exceed an amount of **$2,700**.

2. DEPENDENT CARE ACCOUNT

( ) I hereby elect to make the following contribution to my Dependent Care Flexible Spending Account under the Plan and hereby agree that the annual contribution will be made in equal amounts each pay period, through payroll deduction:

$___ total for the plan year ___ 20 payments (10 month employees) ____24 payments (12 month employees) $_____ for each pay period.

Note: The annual deposit in your Dependent Care Flexible Spending Account cannot exceed **$5,000 ($2,500 for married participants who file separate returns.)**

I understand that the above elections will remain in effect until that last day of the Period of Coverage noted above. I understand that I may change the above elections during the Period of Coverage noted above only if I experience a "Qualifying Life Event", as defined under applicable law, and I may change my elections only in a manner consistent with that "Qualifying Life Event". **Elections are irrevocable unless you experience a Qualifying Life Event. QLEs include a change in your legal marital status, birth or date you adopt a child, death of spouse or dependent, loss of employment, and your child reaches the age 13 or change in childcare services.** Finally, I understand that the elections noted above may need to be modified by the Employer to insure the Plan complies with applicable tax rules.

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_____ _____
Date Signature of Participant

***Return the completed form to David Sherman-Assistant Business manager-Benefits, in the Business Office.**