POUGHKEEPSIE CITY SCHOOL DISTRICT
FLEXIBLE COMPENSATION PLAN
ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT
Period 1/1/2024 to 12/31/2024

1. PERSONAL DATA-(Please Print)

Name_____
(Last) (First) (MI)

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

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

Email _____ **Work Phone**_____ **Home/Cell Phone** _____

Qualified expenses incurred during the plan year 01/01/2024-12/31/2024. You have 90 days after the plan year to file your claim. All claims for expenses incurred from 01/01/2024-12/31/2024 must be postmarked no later than 03/31/2025, or your claim will be denied for late filing.

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 **$3,200.00.**

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.

Qualified expenses incurred during the plan year 01/01/2024-12/31/2024. You have 90 days after the plan year to file your claim. All claims for expenses incurred from 01/01/2024-12/31/2024 must be postmarked no later than 03/31/2025, or your claim will be denied for late filing

I understand that when I submit a claim, I must include appropriate documentation (e.g. explanation of benefits from my Insurance Provider, itemized bill, etc.) for out-of-pocket Medical, Dental, Vision expenses before I can be reimbursed. **All eligible expenses/claims must be incurred during the time that I participate in the plan to be eligible for reimbursement.**

I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize **Poughkeepsie CSD** to make pretax deductions from my salary on the payroll schedule I have elected above.

_____ _____
Date Signature of Participant

"Please return the completed form to Tamisha Greenhill, in the Business Office. Your completed enrollment form must be received in the Business Office no later than November 22, 2023."