



Albert Lea Public Schools - Employee Enrollment Form

Section I

Enrollment Type: <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change in Election <input type="checkbox"/> Other:	Effective Date of Enrollment:
	Enroll in VEBA Plan: <input type="checkbox"/> Single <input type="checkbox"/> Family
	Date of Hire:

Section II – Employee Information

Employee Name		Social Security Number	
Home Address		City, State, Zip	
Telephone Number	Date of Birth	Email Address	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male

Section III – Employee FSA Election

<input type="checkbox"/> <u>Medical FSA</u>	<u>Annual Election:</u> \$ \$3,050 per calendar year max. (For out-of-pocket health, vision and dental expenses for you, your spouse, and your dependent children. Not allowed alongside an HSA)
<input type="checkbox"/> <u>Dependent Care FSA</u>	<u>Annual Election:</u> \$ \$5,000 per calendar year, OR \$2,500 if married filing separately. (For expenses related to childcare of a dependent child or eldercare for elders living in your home which enables you to work).

Section IV – Dependent Information – Required if enrolled in VEBA

SSN #	Name	DOB	Gender	Relation to QB	Address (if different from above)

My signature below indicates that I have read and understand this election form and the descriptive material provided. This election is binding on me and cannot be revoked or modified except under limited circumstances as established by MEDSURETY, LLC and the IRS. I authorize MEDSURETY, LLC to enroll me in the plans I have elected and to reduce my pay by the agreed upon amount(s). I further understand that any contributions for flexible spending accounts will be on a pre- tax basis.

I declare that the information furnished on this form is true, correct, and complete to the best of my knowledge.

Signature: _____ **Date:** _____