



# REIMBURSEMENT ACCOUNT ELECTION FORM

Plan Year January 1, 2023 - December 31, 2023

Employee Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_  
(Please Print)

Address: \_\_\_\_\_  
Street City State Zip

Employee Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Hire Date: \_\_\_\_\_

Email address (required) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Do you want to use the debit card service for 2023? Please Circle  
Yes No

## REIMBURSEMENT ACCOUNTS

	<u>Number of Pays</u>	<u>Annual Amount</u>	<u>Reduction Per Pay</u>
A. Uninsured Health Care	Please Circle 21 or 26 Pays	\$ _____ (\$ 3,050 Max \$60 Min)	\$ _____
B. Dependent Care	21 or 26 Pays	\$ _____ (\$ 5,000 Max \$60 Min)	\$ _____

I UNDERSTAND THAT I CANNOT CHANGE MY ELECTION AND PAY REDUCTIONS UNLESS I EXPERIENCE A CHANGE IN MY FAMILY STATUS. My employer and I agree that my salary will be reduced by the amount(s) listed above for the benefit option(s) I have elected under the Flexible Spending Plan. I hereby acknowledge that I have read the Understanding of Agreements on the reverse side of this form.

Further, I hereby consent to the use of my personally identifiable information, and or my dependent(s)' information, which I have voluntarily provided on this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, or my dependents' behalf, for the sole use of providing benefits, services or any information I have requested.

This agreement is subject to the terms of the Wyandotte Public Schools Flexible Compensation Plan, as amended from time to time, and revokes any prior election and compensation reduction agreement relating to such plan.

\_\_\_\_\_  
Employee Signature Date \_\_\_\_\_

\_\_\_\_\_  
Employer Signature Date \_\_\_\_\_

**RETURN COMPLETED ENROLLMENT FORM TO THE BUSINESS OFFICE BY 12/1/22**