# ADDISON CENTRAL SCHOOL DISTRICT
# FLEXIBLE SPENDING PLAN

## Election of Benefits Form

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|---|---|---|
| **Name (Last, First, MI)** | | **Date** |
| **Mailing Address** | **City, State, Zip Code** | |
| **Social Security #** | **Plan Year** **Jan 1 – December 31, 2023** | **School** |
| **e-mail address** | | **Phone** |

### ELECTION OF HEALTH CARE REIMBURSEMENT

☐ I elect to participate in the Health Care Reimbursement Account for the plan year. (See the "Health Care Reimbursement Worksheet" and list on "Qualifying Expenses") **NOTE**: *Your contribution to the Health Care Reimbursement Account is limited to* ***$3,050 per employee.***

*Over-The-Counter (OTC) benefits are limited to Doctors' Prescriptions only*

Total for Plan Year $_____

☐ I elect NOT to participate in the Health Care Reimbursement Account.

### ELECTION OF DEPENDENT CARE ASSISTANCE

☐ I elect to participate in the Dependent Care Assistance Account for the plan year. The maximum amount which may be allocated to the Dependent Care Assistance Account is $5,000. (This limit may be reduced if you are married and you or your spouse are not employed full time or your spouse is a full-time student or your spouse is unable to care for him/herself. Please see the Plan Administrator for details.)

Total for Plan Year (1 x 2): $_____

☐ I elect NOT to participate in the Dependent Care Assistance Account.

**Employee's Signature:** **Date:**