Flexible Spending Enrollment

Osseo Area Schools

Plan Year: July 1-June 30 **2024**

Employee ID

Effective Date:

Last Name	First Name	Middle Init.

Address	City	State	Zip

Primary Phone	Date of Birth (MM/DD/YYYY) / /	Contract Group

Social Security Number - -	Email Address (Required)

FULL Flexible Spending Account – Health Care

Employee Contribution: $_____ plan year election (Maximum $3,050 per plan year)

☐ Decline Coverage

LIMITED Flexible Spending Account – Vision & Dental Expenses Only

Employee Contribution: $_____ plan year election (Maximum $3,050 per plan year)

☐ Decline Coverage

If you are making or receiving contributions to a Health Savings Account (HSA) you are ineligible to participate in the Flexible Spending Account – Health Care option. Instead, you are eligible for the Limited Flexible Spending option, which is limited to reimbursing only dental, vision and preventive care expenses. Other medical expenses can only be reimbursed through your HSA account.

Dependent Care - Flexible Spending Account

Employee Contribution: $_____ plan year election (Maximum $5,000 per plan year)

☐ Decline Coverage

Enrollment Authorization

I understand that I may be required to provide documentation to substantiate the claim for an expense paid with the debit card and that I must do so within the time frame stated in the request. In the event that I do not provide the required documentation and fail to repay the unauthorized charge; my employer will deactivate the card and consider the charge a debt to the organization and may deduct the charge from my paycheck.

I understand that I am required to supply Further with my email address for purposes of communicating claims information and participation with the Flexible Spending Debit Card is NOT permitted if I fail to supply my email address.

I have reviewed the above elections and understand my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my accounts at the end of the Plan Year may be forfeited.

I understand that group or individual insurance premiums are not an eligible expense under the Health Care Reimbursement Account (this provision applies to both full and limited flexible spending accounts).

_____ _____

Employee Signature Date

Further
P.O. Box 14836, Lexington, KY 40511
Phone: (800) 859-2144 Fax: (866) 231-0214
www.hellofurther.com

☐ **Authorize Electronic Submission**

By checking this box and typing my name, I acknowledge that this constitutes a legal signature confirming that I agree to the these terms as if I physically signed this document.

For HR Use Only **EFP:** **FUR:** **HRS:** **Audit:**

Deductions: ☐ **Full Year** ☐ **August** ☐ **September** ☐ **October**