



The Preferred Group
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WLT10085

Glens Falls CSD PG Blue - FSA Enrollment Form

Your Account Information Is Online
www.ThePreferredGroup.com

— Please Read and Fill Out Carefully

DIRECTIONS: Employee — Complete Sections 1, 2, 3 and 4 then return to your employer
Employer — Complete 'Change Type' Box and complete Section 5

Section 1 Employee Information			
Employer Group # 10085	Employer Group Name Glens Falls CSD	Plan Year 1/1/2025 to 12/31/2025	Social Security Number _____-_____-_____
Employee Name (First Name) _____		(Last Name) _____	
Employee Address (Street, Apt. #) _____ _____ _____			Date of Birth (mm/dd/yyyy) ____/____/____
Employee Address (City, State, Zip Code) _____, _____ _____			
Home Phone _____	Cell Phone _____	Email Address (Please allow email from benefitsinfo@thepreferredgroup.com) _____	
Section 2 Flexible Spending Plan Benefit Elections Return to Payroll Office			

I accept the opportunity to have deductions withheld from my paycheck for eligible employer sponsored medical, dental, vision, and other health insurance related premiums on a pretax (before tax) basis for my entire share of my employer's group health insurance premiums, unless I indicate below not to do so. I understand that this pre-tax premium election will be automatically renewed each year unless revoked by me in writing prior to the beginning of a new Plan Year.

I waive (do not want) the opportunity to have my insurance premium(s) withheld on a pretax (before tax) basis.

Account Type	Fund#		New Election		
MEDICAL FSA (\$200 min/\$3,300 max)	1				
DEPENDENT DAY CARE (\$5,000 max/\$2,500 if married, filing separately)	2				

Section 3 Reimbursement Options	
If you wish to have your reimbursements directly deposited to your bank account, please fill in the line below.	
Direct Deposit Setup: Bank Name _____ Routing # _____ Acct # _____	
Initial to Request Debit Card _____ (Medical spending account only \$18 annual fee)	

Please note: By entering the above information you are enrolling into these specified programs and are validating your dependent information. For more information on these options including the timing of reimbursements, please see your Summary Plan Description.

Section 4 Signature and Acceptance of Rules of Flexible Spending Plan Rules
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Salary Redirection Agreement (Please read and sign below): I have read and understand the explanation I have received regarding my options under this Flexible Benefits Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. I understand that I am only entitled to the amount of the above elections and cannot change any of my elections during the plan year (unless I have an acceptable change in status), and that any money left in my account(s) at the end of the plan year will be treated in accordance with my employer's FSA plan document.

Employee Signature _____	Date _____
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Section 5 Employer's Section — Payroll Information for Salary Reduction Changes					# Payrolls __20/ __26
Fund	First Payroll Date	Last Payroll Date	YTD Deductions	Per Payroll Deduct	Use 'First Payroll Date' and employer signature ONLY if the employee is making a <i>mid-year</i> election. Use the 'Last Payroll Date' and 'YTD Deductions' if changing an <i>old</i> election or termination.
FSA					
DCA					
Employer Signature _____				Date _____	