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Flexible Spending Account Enrollment Form

Section I. Employer/Employee Information PLEASE PRINT

Employer Name:	Group Number:		Employer Location (if applicable):	
Proviso Township HS District 209	98010			
Employee Name:	**Sex:**	**Employee SSN:**	**Date of Birth:**	**Flex Plan Year:**
Address:		**City:**	**State:**	**Zip:**
Employee E-mail Address:		**Daytime Phone:**		

Section II. Election(s)

Use the table below to select your Flex benefits.

	Annual / Mid-Year election pledge	Divided by	# of pay periods of the: annually (Plan Year) / Mid-Year	Equals	Deduction from each pay period
☐ I elect to participate in the Health Flexible Spending Account	$	/		=	$
☐ I elect to participate in the Dependent Care Assistance	$	/		=	$
(Plan Year Example)	$ 2,400.00	/	24	=	Example $100.00

Section V. Participant Certification

I certify the above information to be correct. I understand that any amounts which are not used for eligible expenses incurred during the Plan Year or Grace Period, will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the salary reduction(s) will be in effect for the Plan Year and cannot be revoked except as authorized by current Plan provisions and laws.

Employee Signature:	Date:

IF YOU DECLINE PARTICIPATION: The benefits of the Plan have been thoroughly explained to me and I decline participation.

Employee Signature:	Date:

Employer Use Only

Employee's Flex Plan Effective Date	First Payroll Date	Payroll Cycle	I agree this form is correctly filled out by the Employee. HR Signature: