

YUMA UNION HIGH SCHOOL DISTRICT # 70
REIMBURSEMENT SPENDING AND DEPENDENT CARE ACCOUNT AGREEMENT

Employee Name: _____ School Year: _____

Email: _____ Cell Phone: _____

Mailing Address: _____ Pay Period: 23 / 26

DOB: _____ Effective Date: _____
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“REIMBURSEMENT SPENDING ACCOUNT”:

Eligible Expenses include Deductible, Co-payments, Co-Insurance, Dental, Vision, Prescriptions, and other non-covered medical expenses.

\$ _____

The amount for 2026-27 can be no more than **\$3400** annually and will be divided by pay cycle selected. YUHSD payroll will round amount to work with pay cycle each employee has chosen.

“DEPENDENT CARE ACCOUNT”:

Eligible Expenses from Day Care Centers for dependents under age 15, disabled child(ren), spouse, parent.

\$ _____

(Amount **CANNOT BE MORE** than \$3,750 if filing single or separate returns, and \$7,000 if filing joint)

Your selections are **irrevocable** during the effective period except for changes in family status (e.g. birth, death, marriage, divorce, adoption, or change in your spouse's employment).

I agree that my employer may change or suspend the reduction of compensation if the Internal Revenue Service, through legislation of restrictive regulation, limits or prohibits salary reduction under section 125(g) of the Internal Revenue Code.

I understand that services must be incurred by June 30th. All claims must be submitted for reimbursement within 30 days from June 30th. Any amount remaining up to \$680.00 at that time, for medical flex only, shall be rolled over to the next plan year. Any amount over **\$680.00 will be forfeited.**

Further, I accept responsibility for the proper treatment of benefits paid under this plan with respect to all individual income tax reporting.

Employee Signature: _____

Date: _____

****This form must be received by the YUHSD Payroll Department by June 15th****