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One Dodge Street
North Greenbush, NY 12198
(518) 283-8500

FLEXIBLE SPENDING ACCOUNT

EMPLOYEE/EMPLOYER ELECTION FORM/COMPENSATION REDUCTION AGREEMENT * Required *

COMPANY/CLIENT NAME **Dobbs Ferry UFSD**		
EMPLOYEE NAME *	DATE OF BIRTH* / /	DATE OF HIRE* / /
SOCIAL SECURITY NUMBER*	EMPLOYEE PHONE NUMBER* ☐ Mobile ☐ Home ☐ Work	
ADDRESS: STREET, CITY, STATE, ZIP * ☐ **New Address**		
EMPLOYEE EMAIL ADDRESS* **(REQUIRED)**		

ELECTION:

First payroll date _____ **(REQUIRED Employer - Office Use Only)**

ACCOUNT	MIN. ELECTION	MAX. ELECTION	ANNUAL ELECTION	NUMBER OF PAY PERIODS	DOLLARS WITHHELD/PAY PERIOD
Unreimbursed Medical Account		**$3,400**		20	
Dependent Care Account (Day Care Expenses for dependents up to Age 13)		**$5,000** ($2,500 if married filing separately)		20	

FSA Direct Deposit: ☐ On File **(FSA)** ☐ New (attach ACH Authorization Form and copy of voided/canceled check)

* In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.

DEPENDENT ENROLLMENT * – List **ALL eligible tax dependents** that can/will be eligible for reimbursements under **Medical and/or Dependent Care accounts.** Must be completed each year*

Dependent Name*	SSN *	Date of Birth *	Relationship *

PLEASE REFER TO YOUR SUMMARY PLAN DESCRIPTION REGARDING FORFEITURES, ROLLOVERS, AND GRACE PERIOD EXTENSIONS, AS THEY MAY APPLY TO YOUR PLAN.

Plan Notes:

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I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning **7/1/2026** and ending **6/30/2027**. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked and I understand that election is required annually to participate. As a participant, I understand that:

- I cannot change or revoke this agreement during the above Plan Year, unless I have a change in my family status as set forth in the Summary Plan Description.
- My pay will be reduced each pay period by the amount of my election(s) shown on page 1, continuing for each succeeding pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my payroll reduction will automatically be adjusted to reflect that change.
- My employer may change the amount of my reduction or otherwise modify this agreement, if it believes that the change is required to satisfy the provisions of the Internal Revenue Code.
- The amount of my compensation reduction will be credited to the appropriate reimbursement account for payment of eligible expenses incurred within the plan year.
- Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer, on demand, for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense that I receive.
- **Upon request, I will provide the Claims Administrator with the information (e.g., detailed receipts, itemized statements, etc.) needed to substantiate the expenses submitted for reimbursement, if needed by the Claims Administrator to satisfy the relevant IRS regulations, and that my failure to provide the required documentation will result in the deactivation of my debit card and a repayment request.**
- If there is a remaining balance in my account(s) at the end of the Plan Year (i.e., after all eligible claims have been reimbursed), I may forfeit that excess amount, based on the provisions of the Plan as detailed in the Summary Plan Description.
- By my signature, I hereby certify that any amounts reimbursed to me under this Plan will not be claimed as a deduction on my personal income tax return and will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan

PLEASE NOTE: The pay reductions will not be effective for any pay period that begins before you have signed this form and returned it to your Employer. Please keep a copy of this form for your records.

CHANGES/TERMINATIONS (Employer – Office Use Only)

Date of Event: ____/____/____
First paycheck date that change will be processed: ____/____/____.

___ Marriage/Divorce
___ Birth/Death of Spouse or Dependent
___ Spouse's employment commenced/terminated
___ Status change from full-time to part-time or part-time to full-time by employee or spouse
___ Unpaid leave of absence by employee or spouse
___ Open Enrollment
___ Employment Termination

Employee Signature_____ Date_____

Employer Signature _____ Date _____

HUMAN RESOURCES – OFFICE USE ONLY (ALL FIELDS REQUIRED)

Highly Compensated ❑ Y ❑ N
Key Employee ❑ Y ❑ N
Officer ❑ Y ❑ N
Spouse or Dependent of Owner ❑ Y ❑ N
More than 5% Owner ❑ Y ❑ N
More than 1% owner with salary greater than $150,000 ❑ Y ❑ N