



BEDFORD CENTRAL SCHOOL DISTRICT

Payroll & Benefits Department

2027 FLEXIBLE SPENDING ENROLLMENT/ SALARY REDUCTION AGREEMENT

Last Name	First Name	Social Security Number		
Address		City	State	Zip
Phone Number		Date of Birth		
Employer Name:		Plan Year		

You must check "I elect" or "I decline" for each program.

HEALTHCARE FLEXIBLE SPENDING PROGRAM (FSA)

☐ I elect to participate in the Healthcare Flexible Spending Program. I direct and authorize my employer to reduce my annual salary for the above plan year by the amount noted below to be deposited into my Healthcare Flexible Spending Account.

NOTE: The Annual Maximum for 2027 is projected to be **\$3,500**. Please indicate a dollar amount below.

\$ _____
Annual Amount Number of Pays (enter 20 or 25) \$ _____
Amount per Payroll Deduction (amount divided by pays)

Number of Pay Periods: **20 pays for 10-month employees / 25 pays for 12-month employees**

☐ I decline – I will not be participating in the Healthcare Flexible Spending Program.

DEPENDENT CARE PROGRAM (DCFSA)

☐ I elect to participate in the Dependent Care FSA Program. I authorize my employer to reduce my annual salary for the above plan year by the dollar amount noted below to be deposited into my Dependent Care FSA Account.
(Annual maximum: \$7,500 or \$3,750 if married and filing separately)

\$ _____
Annual Amount Elected Number of Pays (enter 20 or 25) \$ _____
Amount per Payroll Deduction (amount divided by pays)

Number of Pay Periods: **20 pays for 10-month employees / 25 pays for 12-month employees**

☐ I decline – I will not be participating in the Dependent Care FSA Program.

DEBIT CARD PROGRAM

I hereby authorize Health Equity to enroll me in the debit card program. I understand it is to be used for eligible expenses that will be deducted from my Flexible Spending Account(s) and I must keep my receipts for verification. I understand that should my employment terminate, my debit card will be discontinued on my last day of employment with the district. **There will be a \$5.00 charge for lost, stolen or additional cards requested.**

☐ Yes

☐ No

DEPENDENT INFO – Please list dependents eligible under the health care flexible spending plan and/or dependent care plan benefit.

Dependent #1 Full Name and Date of Birth

Dependent #2 Full Name and Date of Birth

Dependent #3 Full Name and Date of Birth

Dependent #4 Full Name and Date of Birth

AUTHORIZATION:

I have read all the enrollment literature explaining these benefits. I understand that any contributions to the account can only be used to reimburse eligible expenses under the account and that I forfeit any funds remaining in my account if my employment terminates for any reason, including retirement, or at the end of the plan year in accordance with IRS regulations. I further understand that I may not change my contributions during the plan year unless I have a Qualifying Event.

Furthermore, my Social Security benefits may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll deductions as contributions to my Healthcare Flexible Spending Program and/or Dependent Care Program as indicated above.

Employee's Signature: _____

Date: _____