GREAT NECK UNION FREE SCHOOL DISTRICT
FLEXIBLE SPENDING COMPENSATION PLAN
ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT
PERIOD OF COVERAGE – 01/01/2027 THROUGH 12/31/2027

---

1. PERSONAL DATA -Please print

Name_____
_ (Last) (First) (Ml)
Marital Status: _____ Birth date_____ Soc. Sec ---------- _____

Address_____
____ (Street) (Apt. #) (City) (State) (Zip)

Email _____Work Phone_____Mobile _____

DEPENDENT INFORMATION (List ALL eligible Dependents Affected by Enrollment- attach additional sheet if necessary)
If you, your spouse, or dependents already have a Benefit Debit Card there is no need to request another Card (please leave the box empty).
Only request a replacement card if your card is lost/stolen, expiration date or if you are enrolling for the first time.

Last Name	First Name	Relationship (Self/Spouse/Child)	M/F	SS#	Date of Birth	Debit Card Yes
Employee		*Self*				
Dependent						
Dependent						
Dependent						
Dependent						

2. FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS

( ) HEALTH FLEXIBLE SPENDING ACCOUNT –The annual deposit in the Health Care Flexible Spending Account cannot exceed an amount of **$3,500 or a minimum $200.00.**

Annual election amount $_____ (contribution will be made in equal amounts over twenty (20) pay periods, through payroll deductions).

( ) DEPENDENT CARE ASSISTANCE PLAN - The Plan Year maximum cannot exceed **$7,500 ($3,750 for married Participants who file separate returns).**

Annual election amount $_____ (contribution will be made in equal amounts over twenty (20) pay periods, through payroll deductions).

Qualified expenses incurred during the plan year 01/01/2027-12/31/2027. You have 90 days after the plan year to file your claim. All claims for expenses incurred from 01/01/2027-12/31/2027 must be postmarked no later than 03/31/2028, or your claim will be denied for late filing.

3. AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event (QLE). I may then revoke my prior election and sign a new Agreement if such a change occurs. QLEs include a change in your legal marital status, birth of a child, date you adopt a child, death of spouse or dependent, loss of employment, or your child reaches the age 13 or change in childcare services. Changes must be submitted within 30 days of the qualifying life event (QLE).

4. ROLLOVER UNUSED FUNDS FROM YOUR HEALTHCARE FSA- PLAN YEAR 2027 TO 2028

I understand the IRS has made a modification to the Flexible Spending Cafeteria Plan (FSA) allowing up **to $700.00** of unused money at the end of a plan year (2027) in a health FSA, these monies are paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year **01/01/2028-12/31/2028.** The unused amount up **to $700.00 t**hat a plan may permit an individual to carry over to the next plan year even if you choose not to enroll in the **2028** FSA plan.

I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize Great Neck UFSD to make pretax deductions from my salary on the payroll schedule I have elected above.
I hereby agree to pay the administrative fee for my account(s) and agree that the annual contribution of $50.00 will be made in equal amounts each pay period.

Employee's Signature _____Date: _____

Deadline for enrollment is Wednesday November 25, 2026. If interested in participating in this employee benefit, please return the completed forms to the Payroll Department no later than Wednesday November 25, 2026.