Varipro
BENEFIT ADMINISTRATORS

Smart About Benefits™

HEALTH AND DEPENDENT CARE

Flexible Spending Account Election Form

Plan Year: January 1, 2017 - December 31, 2017

PLEASE INDICATE NAME OF EMPLOYEE GROUP:

Charlotte Public Schools

Medical Plan Elected for 2017:

_____ HSA _____ Non-HSA _____N/A

Please complete the entire form and return it to your Human Resources Department.

Note: This form must be completed and returned even if you are not enrolling in the Flexible Spending Accounts.

Name____ Social Security _________________
First, Middle, Last

Street Address____________________________________ Date of Birth___________________

City______________________________________ State___________ Zip Code______________

Division____ Date of Hire ________________

E-mail address (optional): ____

Payroll Schedule (please circle): Weekly Bi-Weekly Semi-Monthly Monthly

Optional: Work #: ______________________ Home #: ______________________
Fax #: ______________________

Please list dependent information if provided FSA reimbursements in your plan:
(First, Middle, Last)

1. Dependent__________________________Relationship____________Birthdate________
2. Dependent__________________________Relationship____________Birthdate________
3. Dependent__________________________Relationship____________Birthdate________
4. Dependent__________________________Relationship____________Birthdate________
5. Dependent__________________________Relationship____________Birthdate________
6. Dependent__________________________Relationship____________Birthdate________

BEFORE –TAX PAYROLL DEDUCTION OPTIONS (Flexible Spending Accounts)

HEALTH CARE ACCOUNT Maximum election of $2,500.
DEPENDENT CARE SPENDING ACCOUNT (Day Care) Maximum election of $5,000.00 filing jointly; $2,500 married filing separately.

	Amount Per Pay Period	x	# of Pay Periods	=	Election Amount
Health Care Election:	____________	x	__________	=	$ __________
Dependent Care Election:	____________	x	__________	=	$ __________

________ I do not wish to participate in the Health Care Spending Account.
________ I do not wish to participate in the Dependent Care Spending Account.

I understand that these accounts may only be used for my dependents as defined under the plan and that my choices above must remain in effect for the entire plan year unless I have a qualifying event as defined in my summary plan document (SPD). I also understand that any unused balances in either account at the end of the plan year shall be forfeited. I hereby give my employer permission to reduce my salary by the above elected amount(s).

Signature: ____ **Date:** ______________________