benefit strategies LLC

ELLINGTON PUBLIC SCHOOLS
FLEXIBLE BENEFIT PLAN ENROLLMENT FORM
Jan 1, 2022-Dec 31, 2022

Employee Information ***Please Print Clearly!***

Name: _____ **Social Security Number (Required):** _____

Home Address:
Check if New: ☐ _____

City: _____ **State:** _____ **Zip Code:** _____ **Day Phone:** _____

E-mail Address (Required): _____ **Date of Birth:** _____

1. **Dependent Care Assistant Account** Eligible dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

$	X		=	$
Your Contribution Per Pay Period		# of Pay Periods 21 or 26 if you receive a balloon check you will need to be on the 26 deduction cycle		Total Election

Maximum Election allowed
$5,000

This enrollment form will be for claims dates of service **Jan 1, 2022- December 31, 2022.**

C. *FlexExpress*© Debit Card If you are a new enrollee a set of 2 FlexExpress Cards© will be mailed out to you automatically. If you and/or your dependents already have debit cards, they will automatically be reactivated. Otherwise, please indicate your selection below.

☑	FlexExpress Cards© Debit Card	You will automatically receive a set of 2 FlexExpress Cards©

Additional Card Information: Please indicate the number of *additional* cards you would like to request below (If you request a card for yourself you will get 2 to start). Please note that cards are ordered in multiples of 2. (Example: 2, 4, 6, 8, etc.) Additional sets are 5 per set. Paid By: Employee

Number of Additional Sets Requested:

D. Direct Deposit Authorization If you would like non debit card reimbursements to be direct deposited to your bank account (rather than receiving paper checks) fill out the information below EACH PLAN YEAR AND attach a voided check. If you do not complete this information each plan year you will be defaulted to check.

Bank Name:
(See #1 on sample)

☐ Checking Account
☐ Savings Account

Routing Number – 9 digits (See #2 on sample):

Account Number (See #3 on sample): _____

SAMPLE

E. Signatures By signing below, I agree to the following terms and conditions:

- I cannot change this election during the Plan Year unless I have a qualifying change in family status.
- I must make all of my elections carefully and conservatively. Expenses from Reimbursement Accounts *cannot* be reimbursed from any other source and *must* be incurred during the Plan Year. Any money unclaimed from my reimbursement account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back.
- For expenses reimbursed through this account I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits.
- The IRS requires me to keep documentation of all my expenses claimed and supply them to Benefit Strategies if requested.
- I have read and understood all of the plan details outlined in my Summary Plan Description.

Employee Signature (required):		**Date:**	
Employer Acceptance (required):		**Benefit Effective Date:**	
		First Payroll Date:	