Enrollment Form: Flexible Spending Account

PacificSource ADMINISTRATORS

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EMPLOYEE INFORMATION

Employer name: **Eugene School District 4J**	Effective date: **___/___/2017**
Employee name:	Date of birth:
Mailing address:	
Home phone:	Work phone:
Employee ID:	Email:

ACCOUNT INFORMATION

Beneficiary*: _____ Relationship: _____

*Please designate someone over the age of 18 to be the beneficiary for your account. This person will be responsible for submitting claims in the event you are not physically able to do so. The beneficiary does not need to be related to you.

Please indicate your employment type:

☐**Administrative** ☐**Licensed** ☐**Classified—12ck** ☐**Classified—10ck**

I request the following amounts to be reduced from my paycheck:

	Monthly Amount	**Annual Amount**
Dependent Care FSA ($416.66/mo maximum)	$ _____	$ _____
Health Care FSA* ($2550 annual maximum)	$ _____	$ _____
TOTAL AUTHORIZED REDUCTIONS	$ _____	$ _____

Health FSA elections CANNOT be changed mid-year. Please plan carefully.

AUTHORIZATION

I hereby certify the above information to be correct and true to the best of my knowledge, and that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support*. I understand that Health Care FSA amount above $500 remaining in my account(s)* or any amounts remaining in my Dependent Care Account not used for eligible expenses incurred during the Plan Year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the flexible compensation reductions will be in effect for the Plan Year and cannot be revoked unless I experience a qualified change in status. I also understand that the above reductions may correspondingly reduce my future Social Security benefits.

Signature: _____ **Date:** _____