Frederick County Public Schools

Flexible Spending Account

Election Form for the period October 1, 2017 through September 30, 2018

Employee Information (Please Print Clearly) **FCPS ID#:**

Name: **Social Security #:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address:

City: **State:** **Zip:**

Email:

General Information:

Health Flexible Spending Accounts and Dependent Care Daycare Flexible Spending Accounts allow you to set aside PRE-TAX dollars for reimbursement.

If you participate in the High Deductible Health Plan (HDHP) with a Health Savings Account, you are not eligible to participate in the Health Flexible Spending Account.

Health FSA is reimbursement for out-of-pocket medical expenses for you, your spouse, and your dependents. Some qualifying expenses include: dental, vision, prescriptions, orthodontics, deductibles, and co-pays. The maximum annual election amount can total no more than $2,600 in a calendar year.

Dependent Care FSA is reimbursement for work-related dependent daycare expenses for dependents under the age of 13 or incapable of self-care. Care may be provided by an individual or licensed day care facility for full-time, after school, or summer care. The maximum annual election amount can total no more than $5,000 (if filing head of household, or married filing jointly) or $2,500 (if married filing separately) in a calendar year.

Elections: (annual amounts 10/1/17--9/30/18)

	Monthly Amount	Annual Amount
Health Care FSA		
_____ I certify that I do not participate in the HDHP with a Health Savings Account		
_____ I elect to participate and contribute to a Health Care FSA the following amount	$	$
Annual Total (not to exceed $2,600; $216.67/month)	$	$

Dependent Care FSA		
_____ I elect to participate and contribute to a Dependent Care FSA the following amount	$	$
Annual Total (not to exceed $5,000; $416.67/month)	$	$

Authorization: I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my elections above, with the "tax protected" funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year, unless I experience an eligible change in status, cost or coverage change, or other event listed in the applicable regulations. I further understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year.

However, I will have a specified period of time after my period of coverage to submit claims for expenses incurred during the plan year.

I further certify that I do not participate in a Health Savings Account.

Employee Signature X **Date:**