WARREN CONSOLIDATED SCHOOLS
REIMBURSEMENT ACCOUNT ELECTION FORM

Plan Year January 1, 2021-December 31, 2021 **Union Local: 1346**

Employee Name: _____
(Please Print)

Employee Number_____ Social Security Number_____

Date of Birth_____/_____/_____ Gender: Male/Female
Please Circle

Address: _____
(Please Print) Street City State Zip

Email address (required) District or Home_____
Please Circle

Home Phone: (_____) _____ Work Phone: (_____) _____

REIMBURSEMENT ACCOUNTS Effective Date: **January 1, 2021**

A. Employer Ceded $ _____(Full time)

Employer Ceded $ _____(Part time who pay 50% of medical insurance premium)

B. Medical Reimbursement $_____ Annual……. $2,750 Maximum $60 Minimum per year

C. Dependent Care $_____ Annual……. $5,000 Maximum $60 Minimum per year

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I UNDERSTAND THAT I CANNOT CHANGE MY ELECTION AND PAY REDUCTIONS UNLESS I EXPERIENCE A CHANGE IN MY FAMILY STATUS. My employer and I agree that my salary will be reduced by the amount(s) listed above for the benefit option(s) I have elected under the Flexible Spending Plan. I hereby acknowledge that I have read the Understanding of Agreements on the reverse side of this form.

Further, I hereby consent to the use of my personal identifiable information, which I have voluntarily provided on this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, for the sole use of providing benefits, services or any information I have requested.

This agreement is subject to the terms of the Warren Consolidated Schools Flexible Compensation Plan, as amended from time to time, and revokes any prior election and compensation reduction agreement relating to such plan.

_____ Date _____
Employee Signature

_____ Date_____
Employer Signature

PLEASE SUBMIT TO EMPLOYEE BENEFITS DEPARTMENT
BY NOVEMBER 13, 2020 AT 4:30 PM

TERMS AND CONDITIONS

I have received the printed material explaining the Plan and my options under the Plan, and, I understand that by signing this form, I am making an election which may not be changed for this Plan Year other than as permitted by law and the Plan. Further, I understand that if I do not incur expenses this Plan Year in the amount which I have elected for each benefit, the law requires that I forfeit unused amounts, resulting in a loss of take-home pay.

I authorize the reductions of these amounts from my paychecks and acknowledge that these amounts are to be credited to my Flexible Compensation accounts. I authorize the Administrator to draw upon my accounts to reimburse me for eligible expenses incurred by me during the Plan Year. I understand that requests for reimbursement from the reimbursement plan(s) will only be processed if I comply with the terms and conditions of the applicable plan. I also understand that the Plan Administrator and Third Party Claims Administrator may establish rules and procedures from time to time, which also govern processing reimbursement requests. In addition, the Plan Administrator may establish rules and procedures regarding payment of remaining reimbursement contributions upon termination of employment in accordance with the applicable Flexible Benefit Plan Document(s). The Employer and Plan Administrator may take appropriate legal action to assure that reimbursements are made in accordance with the terms and conditions of the reimbursement plan(s).

DEPENDENT CARE REIMBURSEMENT

I understand that, for this Plan Year, I may be reimbursed for dependent care expenses up to the maximum of (1) Five Thousand Dollars ($5000) (Two Thousand Five Hundred Dollars ($2500) if married filing separate), (2) my spouse's earnings, if applicable, or (3) 50% of my earnings, whichever is least. I also understand that in order to receive reimbursement, I must submit receipts or other evidence that indicate who was cared for, dates of service, the actual amount paid along with the name, address and social security/tax identification number for the provider of these services. I understand that I or my spouse, if applicable, may not elect to receive the tax credit for the dependent care expenses that I have been reimbursed for under the Plan.

HEALTH REIMBURSEMENTS

I understand that, for this Plan Year, I may be reimbursed for expenses incurred for my medical care and the medical care of my spouse and dependents which are not covered by medical insurance or other plans up to the maximum amount deemed by the Plan. The "dependent" relationship must exist when the charges were incurred. If I claim reimbursement for these expenses under the Plan, the amount of the reimbursement will be tax free. (Maximum cannot exceed Two Thousand Seven Hundred and Fifty Dollars ($2,750) per Plan Year.

Eligible medical expenses include any expenses incurred for diagnosis, cure, treatment, mitigation, or prevention of disease, or for the purpose of affecting any bodily function or structure, prescription drugs or insulin.

PLAN YEAR 01/01/21 – 12/31/21

Medical Reimbursement Account	$2,750.00 Annual Maximum
Dependent Care Account	$5,000.00 Annual Maximum

NEW: **DEPENDENT CARE BENEFIT:**

IRS extension amendment included allows 2 ½ months grace period for Dependent Care Reimbursement Claims incurred by March 15, 2022 and submitted by March 30, 2022.

MEDICAL FSA BENEFIT:

All expenses must occur on or before 12/31/21.
ALL PAPER CLAIMS MUST BE SUBMITTED TO EBC BY (NOON) 12:00 PM 12/31/21
ALL DEBIT CARD SWIPES / TRANSACTIONS MUST BE DONE BY (NOON) 12:00 PM 12/31/21.

YOU ARE CAUTIONED TO BE CONSERVATIVE!! It is better to UNDERESTIMATE your needs than to overestimate them. Remember, you can only change your cafeteria plan once each year. Once selections are made; you must live with them for the next 12 months!