SISC FLEX
Health/Dependent Care Enrollment Form

School District *(Qualified Employer)*	

Employee Information (Please print clearly)

NAME:	**First** **MI** **Last**	**SS#:**	**DATE OF BIRTH:**
ADDRESS:	**Street Address or P.O. Box** **City** **State** **Zip**		**PHONE:** **( )**
Email *(Optional)*			**Date of Hire**

☐ **Open enrollment** ☐ **New employee**

Job Title _____ Yearly Salary: _____ (Information required for IRS discrimination testing purposes.)

Benefit Elections and Salary Reduction Authorization

Spending Account Elections: *I request the following amounts be deducted from my pay with pretax dollars:*

	Total $ for Plan Year		**Pay Periods Per Year***		**$ Per Pay Period**
Health Care Spending Account *(Health Care Expenses)*	$_____ $5,000 Maximum	/	_____	=	**$**_____
Dependent Care Spending Account *(Daycare Expenses)*	$_____ $5,000 Maximum	/	_____	=	$_____

***PLEASE LIST ANY MONTHS WHEN YOU DO *NOT* RECEIVE A REGULAR PAYCHECK.** _____

List a*ll* Dependent Children, Including Spouse or Domestic Partner*. *Only those included on this form will be eligible*

Dependent(s), and/or Spouse's or Domestic Partner's First, M.I. and Last Name	**Relationship**	**Social Security No.**	**Date of Birth**
	☐**Spouse** ☐**Domestic Partner**		
	☐**Son** ☐**Daughter**		
	☐**Son** ☐**Daughter**		
	☐**Son** ☐**Daughter**		
	☐**Son** ☐**Daughter**		

The Following Information is Required For Enrollment in The Dependent Care Spending Account Only:

Marital Status of Participant (Employee) _____ Spouse's Wages_____

If not employed, is spouse incapacitated or a student? _____

Are the daycare, homecare or childcare expenses necessary to enable the Participant to be gainfully employed? _____

Agreement:

I have received, read and understand the SISC Flex Plan Employee Brochure and the SISC Flex Debit Visa Card questions and answers document. For Spending Accounts**,** the amount(s) I have elected will be taken from my pay in equal installments. I understand that if I fail to submit eligible claims for the total amount elected for the Plan Year, I forfeit any remaining balance. The election(s) will continue throughout the Plan Year or until I submit a valid change form indicating a qualifying Status Change. For Dependent Care Spending Account claims, I understand that I must submit the caregiver's tax identification number with each claim. Under penalty of perjury I certify that this amount does not exceed any IRS guidelines for annual limits.

Signature_____ Date: _____

Employee Initial's _____ I have taken into consideration the OTC restrictions when completing my annual election form.

Return the completed form to your employer

School District's *(Qualified Employer's)* use only

Received and approved by authorized School District Administrator: _____ Date:_____

Effective date of enrollment: _____ First payroll deduction date: _____

Revised 08/17/2010 Copy – White (SISC Flex) Yellow – (School District) Pink – (Employee)