North Ridgeville City Schools FlexSave Enrollment Form

Please Print. All information is required or your enrollment cannot be processed

Section I. Employee Information

Employee Last Name:	**First Name:**	**Date of Birth** MM/DD/YYYY
Employee Home (Street) Address:		**APT.**
City:	**State: OH**	**Zip:**
Employee S.S.#:	**Date of Hire: MM/DD/YYYY**	**Phone Home:**
Cell Phone:	**E-mail**	

Plan year start Date 1/1/2021 and ends 12/31/2021. First payroll start date 1/1/2021
No of Pays 24

Section II. Health Care Account – Flexible Spending Account (FSA)

☐ Yes, I elect to contribute $_____.00 ($2,500.00 maximum before taxes) for the Year (January – December), which is $_____.00 twice each month to fund my account that pays qualified out-of-pocket healthcare expenses that are not covered by my employer's health plan or any other health plan.

☐ No, I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

Section III. Dependent Care Account

☐ Yes I elect to contribute $_____.00 ($5,000.00 maximum (if you are married filing a joint return or head of a household) or $2,500 (if you are married and filing separate returns) for the Year January – December), which is $_____.00 twice each month to fund my account that pays qualified dependent day care or elder care expenses.

☐ No, I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

Section IV FlexSave Monthly Administrative Fee

I understand that by electing to enroll in the FlexSave HealthCare and/or Dependent Care I will be charged a plan year administrative fee of $66.72 which is in addition to the amount that I indicated under Section II and Section III above. This charge will automatically be withheld from my paycheck $2.78 twice each month.

Important– Please read the following before signing this enrollment form. My employer and I agree that my taxable income will be reduced twice each month during the year by an equal portion of the benefit elections (selected above) set forth above in addition to the monthly administrative fee and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read and understand the Summary Plan Description. I understand that the take care flex benefits card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the flex benefits card, I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my card. I also understand that if a payment is made that is not for qualified expenses, I will repay The Fund. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck.

Employee Signature _____ **Date** _____

COMPLETE THE BACK OF THIS FORM

North Ridgeville FlexSave Payroll Contribution Worksheet

The following is an example to help you understand how your FlexSave contributions will be deducted from your paycheck:

Sue Smith will have a payroll contribution amount of $273.54 twice a month:	
1. FlexSave Plan Year Health Care Account Contribution	**$2,500.00**
2. FlexSave Plan Year Dependent Care Account Contribution	**$4,000.00**
3. FlexSave Plan Year Employee Administrative Fee	**$ 66.72**
TOTAL ANNUAL CONTRIBUTION	**$6,566.72**

Total Annual Contribution Amount divided by number of pay periods (24) equals your payroll contribution amount.

$6,566.72 ÷ 24 = $273.61

Employee Name	
1. FlexSave Plan Year Health Care Contribution	**$**
2 FlexSave Plan Year Dependent Contribution	**$**
3. FlexSave Plan Year Administrative Fee	**$ 66.72**
Total Annual Contribution	**$**
Total Annual Contribution amount divided by 24 pay periods equals your payroll contribution amount.	
Payroll Contribution Amount	**$**