GROUP RESOURCES®

FLEXIBLE SPENDING ACCOUNT
2022 Plan Year

WARREN CONSOLIDATED SCHOOLS

Warren Education Association

Plan Year 1/01/2022-12/31/2022

Benefits include: Dependent Day Care

$5,000 maximum $60.00 per year minimum

Use pre-tax dollars to pay for Dependent Care Services for dependent children through age 12 and elderly dependents!

Dependent FSA- Elect up to $5,000 maximum. Reimburses for day care for children up through age 12 (includes pre-school tuition) for children, latch key, day camps and elder care needed for older adults (IRS allows $5,000 per family per calendar year) Reimbursements made by check or direct deposit.

You may submit claims for reimbursement via fax, mail or scan and email. Reimbursement is made by check or direct deposit.

Please submit completed enrollment form to DIANE MILES in the HR Benefits Department by November 19, 2021 at 4:30 PM

***IRS 2 ½ month extension allows for eligible expenses to be incurred through March 15, 2023 and submitted by March 30, 2023.**

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, 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 Dependent Care Reimbursement Account. I authorize the Administrator to draw upon my account to reimburse me for eligible expenses incurred by me during the Plan Year. I understand that requests for reimbursement from the reimbursement plan 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 separately), (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.

PLAN YEAR 1/01/2022-12/31/22

Dependent Care Account	$5,000.00 Annual Maximum

IRS extension amendment included allows 2 ½ months grace period for Dependent Care Reimbursement Claims incurred by March 15, 2023 and submitted by March 30, 2023.

WARREN CONSOLIDATED SCHOOLS
DEPENDENT CARE REIMBURSEMENT ACCOUNT ELECTION FORM

Plan Year January 1, 2022- December 31, 2022 **UNION: WEA**

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 ACCOUNT **Effective Date:** _____

Dependent Care **$**_____ **Annual..... $5,000 Maximum*** **$60 Minimum per year**
(Five Thousand Dollars ($5000) if single or married and filing jointly, Two Thousand Five Hundred Dollars ($2500) if married filing separately)

My employer and I agree that my salary will be reduced by the amount listed above for the benefit option 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 DIANE MILES IN THE HR BENEFITS DEPARTMENT

Number of Pays left in Plan Year _____