GLENBARD TOWNSHIP HIGH SCHOOL DISTRICT 87 Enrollment Form

- ✓ After completing this form, please sign, date, and return to your HR Department.
- ✓ If you have questions, please contact your Human Resource representative or contact Benefit Advantage at (800) 686-6829, or visit our website at www.BenefitAdvantage.com .

EMPLOYEE INFORMATION

First Name:			Home Phone ( ) -
Last Name:			Work Phone ( ) -
SSN:	Email Address: *Used for notification of payment and receipt of claim.		
Street Address:			City:
State:	Zip:	Effective Date: ______/______/_____	First Pay Period: ______/______/_____

Pay Frequency: ☐ Weekly ☐ Bi- Weekly ☐ Semi- Monthly ☐ Monthly Total # Pay Periods: ____________

PLAN ELECTION DESCRIPTIONS

Healthcare-Flexible Spending Account (FSA) Out-of-Pocket prescription, medical, dental, and vision expenses. Contribute up to $2550.00 for the Plan Year. (Min. $0.00)	☐ YES ☐ NO	Contribution Amount: $_________ Annual Election: $_________
Dependent Care Assistance Program (DCAP) Child and/or adult daycare expenses. If married filing jointly or single – Contribute up to $5000.00 for the Plan Year. If married filing separately – Contribute up to $2500.00 for the Plan Year.	☐ YES ☐ NO	Contribution Amount: $_________ Annual Election: $_________
Direct Deposit (If selecting this option – ALL Bank Information Below is REQUIRED) Used for paper claims sent to Benefit Advantage for reimbursement directly to your bank account. **I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.** Bank NINE digit routing number (Include zeros where present) ___ ___ ___ ___ ___ ___ ___ ___ ___ Bank Account Number: ______________________________ Bank Name: ______________________________________	Select One: ☐ New ☐ Change ☐ Cancel/ Stop ☐ Continue	Account Type: ☐ Checking ☐ Savings

EMPLOYEE AUTHORIZATION

I understand that the choices I have indicated above must remain in effect for the entire plan year unless I have a change in family status. A change in family status includes the birth or adoption of a child, marriage, divorce, death, spouse losing or gaining a job, or a change in employment status from part-time to full-time or full-time to part-time. I hereby authorize my employer to deduct from my salary the required contributions for the amounts I have elected.

Signature:

Date

See additional information on the back of the enrollment form regarding benefits

General Plan Information

- ✓ Glenbard Township High School District 87's Plan Year renews every **January** and runs for 12 consecutive months.
- ✓ Annual Health Care Account maximum is $2550.00.
- ✓ Annual Health Care Account minimum is $0.00.
- ✓ Annual Dependent Care Account maximum is $5000.00.
- ✓ Annual Dependent Care Account minimum is $0.00.
- ✓ Amounts remaining in your Health FSA account at the end of the Plan Year can be used to reimburse applicable expenses that are incurred during a Grace Period. The Grace Period begins on 1/1 and will end on 3/15. Unused amounts remaining in your account at the end of a Plan Year that are not applied to pay expenses submitted on or before the end of the Grace period will be forfeited to the Company.
- ✓ After the Plan Year ends, you have **90 Days** to submit expenses incurred during that plan year.
- ✓ If your employment terminates during the plan year, you will have **90 Days** to submit expenses incurred up to your termination date.
- ✓ Be conservative, the IRS states that any unused funds will be forfeited.
- ✓ Your election will remain in effect for the entire plan year, unless you have a qualifying status change and the change is consistent with the qualifying event.

Healthcare-Flexible Spending Account (FSA)

The Health Flexible Spending Account (FSA) gives you the benefit of allocating money pre-tax for reimbursement of out-of-pocket medical expenses incurred by you and your dependents during a Plan year. Dependents include your spouse, children residing with you, or a parent for whom you claim on your taxes as a dependent. *You do not need to participate in your Company's group insurance plan in order to participate in the Health Care Flexible Spending Account.*

Eligible expenses include, but are not limited to, prescriptions, your medical and dental deductibles, co-pays, vision and hearing care, expenses in excess of "usual, reasonable and customary" charges and other health care costs not covered under your or your spouse's insurance plan.

Dependent Care Assistance Program- (DCAP)

The IRS states that an eligible dependent for the purpose of a Dependent Care reimbursement Plan is a child under 13 years old and living with you. An eligible dependent, regardless of age, may also include your mentally or physically impaired spouse/dependent/child that is living with you regardless of age and incapable of caring for themselves.
To be eligible to participate in this account all of the following must apply:

1. The expenses must be necessary to allow you and your spouse to work, seek employment, or attend school full time.
2. Providers **must** declare the funds you pay them as income on their tax returns.

The IRS states the annual maximum amount a family may withhold in a dependent care plan is the lesser of $5,000 per family, or you or your spouse's income. A single parent is eligible for this program with the above limitations.

If you and your working spouse have dependent care accounts with your employers, the combined contribution may be no greater than $5,000. Married individuals filing separate tax returns can each claim a maximum of $2,500 through a dependent care account.

If you are married and your spouse is a full-time student or unable to care for himself, or herself, you may claim $2,400 if you have one (1) dependent, or $4,800 if you have more than one dependent.