INFINISOURCE
BENEFIT SERVICES

Flexible Spending Account Election Form

2020 Calendar Year (1/1/2020 – 12/31/2020)

Indicate your TSD Pay Schedule

___21 Pay Schedule ___26 Pay Schedule

SECTION 1: Employee Contact information

EMPLOYEE LAST NAME | FIRST NAME / M.I. | LAST 4 DIGITS OF SOC SEC# | EMPLOYEE ID #

Troy School District

EMPLOYER | DAYTIME PHONE # | EMAIL ADDRESS | Check if new

Check if new | STREET ADDRESS | CITY | STATE | ZIP

SECTION 2: Election Information

Employee contributions may only be made based upon the pay schedule indicated above; FSA/DCA Accounts may not be pre-funded

Health Care Reimbursement Plan

O I elect to participate.

$_____ is my PRE-TAX annual election

Cannot exceed $2,700 annually

O I elect NOT to participate.

Dependent Care Reimbursement Plan

O I elect to participate.

$_____ is my PRE-TAX annual election. *Cannot exceed $5,000 annually or $2,500 for an employee who is married and filing a separate tax return).*

O I elect NOT to participate.

By signing this form, I understand that I am authorizing funds to be taken from my paycheck on a PRE-TAX basis and transferred into my Flexible Spending Account based on the Pay Schedule indicated above. The amount that I am requesting to be deducted will reduce my annual taxable wages.

I understand that my election into the Health Care and the Dependent Care Plan(s) cannot be changed during the plan year unless I experience a qualifying change in status.

X

EMPLOYEE SIGNATURE VERIFICATION **DATE**

* Return this enrollment form to your employer benefits department

Infinisource, Inc. has incorporated the HIPAA Privacy Requirements to reflect our organization's business practices regarding your FSA coverage.

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