Siloam Springs School District #21 Cafeteria Plan

FLEXIBLE SPENDING ACCOUNT
SALARY REDCTION AGREEMENT

Plan Year **JANUARY 1, 20___** - **DECEMBER 31, 20____**

Employee NAME(print) _____

Address: _____ **City** _____ **ST** **ZIP** _____

EMAIL: _____ **PHONE** _____

Complete the following to participate in the FSA -Medical / Dependent Care Reimbursement Plan:
Note: You CANNOT be in BOTH the FSA and an HSA

FSA - Medical Reimbursement ($2,750 Max annual contrib. **/ $550** annual rollover) $_____Monthly

Dependent Care Reimbursement ($5,000 Max annl contr) $ Monthly

I authorize my employer to reduce my salary by the amount of the premiums of benefits elected under this agreement. This agreement will remain in effect until the plan year ends, my employment is terminated, or a change in family status occurs.

I understand that on or after the first day of the plan year, I **cannot change or revoke this election** agreement with respect to pre-tax benefits before the next anniversary date of the plan unless a "change in family status" or other qualifying event occurs (i.e. marriage, divorce, death, of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse) , and the change is caused by and is consistent with the change in family status

FSA annual rollover is limited to $550. There is no grace period. I understand that at the end of the plan year (December 31) any unused FSA - Medical Reimbursement amounts **in excess of $550 will be forfeited.**

X_____ _____ _____

Employee Signature Date Witness Signature