BUSINESSPLANS
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New Milford Public Schools Flexible Spending and Dependent Daycare Election Form

EMPLOYEE INFORMATION: *(Completed by Employee)*	
Name:	
Email:	
SSN:	
Address:	
City:	Date of Hire:
State:	Zip Code:
Phone: ☐ Home ☐ Work	Date of Birth:

ENROLLMENT INFORMATION: *(Completed by HR)*	
Date of Plan Entry:	
Date of First Payroll Deduction:	
Assigned Payroll Schedule:	
Total Number of Pay Periods:	
	MED / DEP
Verified Per Pay Contribution:	/
Verified Annual Election:	/

I authorize my employer to make the following salary reductions: *Indicate below the options in which you would like to participate.*

☐ **Flexible Spending Reimbursement Account:***

1. *Deductibles and Co-pays*
2. *Eye Exams and Glasses*
3. *Prescription Drugs*
4. *Non-cosmetic Dental Procedures*
5. *Vitamins and Supplements are not*

Please visit **www.mycafeteriaplan.com for a list of eligible expenses.*

A. Total Per Pay contribution:	**A.**	$
B. Total number of pay periods in plan year:	**B.**	
C. Total Annual Election: *Line A multiplied by line B* ***(Maximum allowed: $ 2,750)***	**C.**	$ 0.00

☐ **Dependent Daycare Reimbursement Account:** *Eligible daycare expenses for eligible dependents*

1. *If married, your spouse must also be employed*
2. *Age limit for dependent children: 12 years of age*
3. *May be used for elderly care if they meet the dependent requirement as defined by the IRS*
4. *Maximum Allowed: $5,000 if single or married filing jointly, $2500 if married filing separately*
5. *Dependent must reside in your household the majority of th*
6. *Tuition expenses for K-12 school* ***are not eligible***

D. Total Per Pay contribution:	**G.**	$
E. Total number of pay periods in plan year:	**H.**	
F. Total Annual Election: *Line D multiplied by line E* ***(Maximum allowed: See #4 above)***	**I.**	$ 0.00

I understand that:

☐ I cannot change this election during the plan year unless I have a change in status as defined by the Internal Revenue Code and Regulations.

☐ Any amount remaining Dependent Daycare reimbursement account and any amount over $550 in my Health and Limited Health Flexible Spending Account at the end of the year will be forfeited.

☐ My Social Security benefits may be reduced by this election.

☐ This election replaces any previous elections and will terminate on the earlier of:

(1) the end of the plan year.
(2) when I am no longer being paid compensation in an amount at least equal to my total salary reduction.
(3) termination of the plan.
(4) termination of employment.

☐ My Employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

☐ I am required to keep sufficient documentation (e.g., invoices and receipts) for all expenses and may be asked to submit such documents to myCafeteriaPlan.

☐ I hereby authorize my employer to payroll deduct any amount equal to the total of all unsubstantiated flex card transactions as reported by myCafeteriaPlan.

Signature: _____ Date: _____

Please return your completed form to your Human Resource Department