FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

DO NOT COMPLETE SHADED AREAS

EMPLOYEE NUMBER	LAST NAME		FIRST NAME		MI
ADDRESS (STREET)	CITY	STATE	ZIP CODE	PHONE NUMBER	
BIRTHDATE	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED	SOCIAL SECURITY NUMBER _ _		

☐ CERTIFICATED
☐ CLASSIFIED

EFFECTIVE DATE	ELIGIBLE DATE	INITIALS	DATE PROCESS	BARGAINING UNIT______ HI_______

PLEASE NOTE THAT UNLESS YOU HAVE A "MAJOR LIFE EVENT" ALL MONIES ELECTED WILL BE DEDUCTED BY THE END OF THE CALENDAR YEAR

Part I - Health Care Reimbursement Account (3902)

I wish to deduct from my pre-tax salary $______________________________ annually*
($120 minimum and $5000 maximum annually)

To continue your elections, you must re-enroll annually during the Annual Enrollment Period.

Part II - Dependent Care Reimbursement Account (3901)

I wish to deduct from my pre-tax salary $______________________________ annually*
($120 minimum and $5000 maximum annually)

To continue your elections, you must re-enroll annually during the Annual Enrollment Period.

***** The number of deductions is 12 for employees on a monthly pay schedule and 24 for employees on a semi-monthly pay schedule.***

AUTHORIZATION I certify the above information to be correct and true to the best of my knowledge and that the individuals for whom I will be claiming dependent expenses or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Spending Account deduction(s) will be in effect for the plan year and cannot be changed unless I experience a "Major Life Event".

I understand that unless I experience a "Major Life Event" <u>all monies elected will be collected</u>. *I understand that if I am not paid during a particular pay period, the remaining FSA deductions will increase to include any missed deductions.* I also understand that these deductions are not carried over to the next plan year. In order to continue my deductions, I must make a new election annually during the Annual Enrollment Period.

Signature____ Date_________________________

Return the completed enrollment form to:

Los Angeles Unified School District
Health Benefits Administration, Flexible Spending Account
P.O. Box 513307
Los Angeles, CA 90051-1307

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