SISC FLEX
Health/Dependent Care Enrollment Form

School District *(Qualified Employer)*	Palisades Charter High School

Employee Information (Please print clearly)

NAME:	First MI Last	SS#:	**DATE OF BIRTH:**
ADDRESS:	Street Address or P.O. Box City State Zip		**PHONE:** ( )
Email *(Optional)*			**Date of Hire**

☐ **Open enrollment** ☐ **New employee**

Job Title ______________ Yearly Salary: ______________(Information required for IRS discrimination testing purposes.)

Benefit Elections and Salary Reduction Authorization

Spending Account Elections: *I request the following amounts be deducted from my pay with pretax dollars:*

	Total $ for Plan Year	Pay Periods Per Year*	$ Per Pay Period
Health Care Spending Account *(Health Care Expenses)*	$______ $2,500 ~~$X,000~~ Maximum	/ 10 months	= $______
Dependent Care Spending Account *(Daycare Expenses)*	$______ $5,000 Maximum	/ 10 months	= $______

*PLEASE LIST ANY MONTHS WHEN YOU DO *NOT* RECEIVE A REGULAR PAYCHECK. NA

List *all* Dependent Children, Including Spouse or Domestic Partner*. *Only those included on this form will be eligible*

Dependent(s), and/or Spouse's or Domestic Partner's First, M.I. and Last Name	Relationship	Social Security No.	Date of Birth
	☐Spouse ☐Domestic Partner		
	☐Son ☐Daughter		
	☐Son ☐Daughter		
	☐Son ☐Daughter		
	☐Son ☐Daughter		

The Following Information is Required For Enrollment in The Dependent Care Spending Account Only:

Marital Status of Participant (Employee) ______________ Spouse's Wages ______________

If not employed, is spouse incapacitated or a student? ______________

Are the daycare, homecare or childcare expenses necessary to enable the Participant to be gainfully employed? ______________

Agreement:

I have received, read and understand the SISC Flex Plan Employee Brochure and the SISC Flex Debit Visa Card questions and answers document. For Spending Accounts, the amount(s) I have elected will be taken from my pay in equal installments. I understand that if I fail to submit eligible claims for the total amount elected for the Plan Year, I forfeit any remaining balance. The election(s) will continue throughout the Plan Year or until I submit a valid change form indicating a qualifying Status Change. For Dependent Care Spending Account claims, I understand that I must submit the caregiver's tax identification number with each claim. Under penalty of perjury I certify that this amount does not exceed any IRS guidelines for annual limits.

Signature ______________________ Date: ______________

Employee Initial's _______ I have taken into consideration the OTC restrictions when completing my annual election form.

Return the completed form to your employer

School District's *(Qualified Employer's)* use only

Received and approved by authorized School District Administrator: ______________ Date: ______________

Effective date of enrollment: January 2013 First payroll deduction date: Feb 10, 2013