Westwood Community School District
Benefits Election Form
2014 Plan Year

Please complete and sign below:

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Social Security Number ___ - ___ - ____

Home Address _____ City _____ State _____ Zip Code _____

Home Telephone Number ( ) _____ Date of Birth ___ / ___ / ___ Date of Hire ___ / ___ / ___

ELIGIBLE DEPENDENTS

Add/Change	Relationship	Name	SSN	Birthdate

FSA ELECTIONS

Medical Expense Flexible Spending Account Elections

For the Plan Year1/1/2014 - 12/31/2014, I elect the following Medical Expense FSA amount:

(Maximum $2,500): $_____ Bi-Weekly Amount: $_____

I understand that by electing FSA coverage, the amount I elect will automatically be reduced Bi-weekly from my wages on a pre-tax basis, and will be used to reimburse me for eligible medical expenses.

I understand that if I do not incur medical expenses this Plan Year in the amount which I have elected under the Medical Expense FSA, the law requires that I forfeit unused amounts, resulting in a loss of take-home pay.

Dependent Care Flexible Spending Account Elections

For the Plan Year1/1/2014-12/31/2014, I elect the following Dependent Care FSA amount:

(Maximum $5,000 [$2,500 married filing jointly; see Summary Description for other limitations])

$_____ Weekly Amount: $_____ (annual 26 pays)

I understand that if I do not incur expenses this 2014 Year in the amount which I have elected under the Dependent Care FSA, the law requires that I forfeit unused amounts, resulting in a loss of take-home pay.

In order to be eligible for this benefit, you will be required to provide the name, address, and social security number (or employer identification number) of the dependent care provider.

TERMS AND CONDITIONS

I authorize Westwwod Community School District to make payroll deductions based on the coverage election(s) indicated above. I understand that all of the foregoing medical and dental elections will be made in accordance with my plan elections for the 2014 plan year. I further understand that if the required contributions for the elected benefit(s) change while this agreement is in effect, my payroll deductions may be automatically adjusted to reflect the change. I will receive appropriate notice of such a change.

I understand that the above election(s) are irrevocable until the next open enrollment period, unless I have a change in family status. A change in family status will include the following: a) marriage or legal separation/divorce/death, b) spouse terminating or obtaining employment, c) transfer to a different employment status (full-time to part-time or vice versa), d) significant change in spouse's health coverage, and e) loss of dependent status or birth or adoption of a child.

Additionally, I understand that all request for reimbursement must be received at EHIM no later than 90 days (3/31/2015) after the plan year ends .

Only benefit changes consistent with the above will be permitted and must be made withn 30 days of the change in family status. I understand that I am responsible for notifying Westwwod Community School District of any change in family status and for completing the necessay forms within those 30 days.

_____ _____
Employee Signature Date

☐ I elect to waive coverage.

_____ _____
Employee Signature Date