Hanford Joint Union High School District
Flexible Spending Account
Compensation Reduction Agreement

for the Plan Year beginning September 1, 2020 and ending August 31, 2021

Employer Use Only
Group No. _____
Corrected _____
Change of Status_____
Effective Date_____
Termination Date_____
Division_____

Last Name	First Name	M.I.	Social Security Number	Date of Hire / /
Home Address Street	City	State	Zip	Date of Birth / /
E-mail Address				

I hereby make the following election(s) or waiver(s) regarding the benefits made available to me under my employer's Flexible Spending Account and acknowledge my understanding that:

- I elect to reduce my annual, taxable compensation by an amount equal to the total value of the benefits specified below;
- the annual amount will be deducted in approximately equal sums from my regular paychecks during the coming Plan Year;
- this election will remain in effect until the last day of the Plan Year during which I am a participant;
- my election may be changed only upon the occurrence of a Change in Family Status as described in the Plan Document;
- by taking less taxable pay, my Social Security benefits could be reduced;
- any amount left in these accounts after the claims submission deadline for expenses incurred during the Plan Year will be forfeited in accordance with Plan provisions and tax laws;
- this form must be completed and returned by August 31, 2020.

Health Care Spending Account Annual Maximum: $2,750

$_____ per Plan Year

☐ waive participation

Dependent Care Spending Account
Annual Maximum: $5,000 ($2,500 for married participant filing a separate Federal income tax form)

$_____ per Plan Year

☐ waive participation

- I have been given the opportunity to participate in the Flexible Spending Account and have indicated my election(s) or waiver(s) above. I acknowledge that I am not eligible to change my participation until the next enrollment period, or if earlier, the occurrence of a Change in Family Status.

Employee Signature _____ Date_____

Daytime Phone Number _____ Evening Phone Number _____

Employee Debit Card

☐ I waive participation in the debit card program.

☐ I elect to use the debit card associated with the benefit account(s) made available to me through my employer and acknowledge my understanding that:

- This debit card is intended only for, and restricted to, use for eligible services and/or purchases associated with my employer's benefit account(s), as governed by the Internal Revenue Service and/or all federal and relevant state laws.
- I am responsible to save receipts related to any debit card transactions and must present receipts to the plan upon request.
- Any expenses for which I use the debit card have not been reimbursed and will not be reimbursed by another health plan.
- I must refund the amount of any expense deemed ineligible under my benefit account.

Spouse Debit Card

☐ Yes, I request a debit card for my legal spouse named below and understand that the above provisions apply to the use of that card.

Spouse's Name _____ (Print)

Spouse's Social Security Number _____

Spouse's Date of Birth _____

Employee Signature _____ Date_____