Allied Benefit Systems, LLC
P.O. Box 211651
Eagan, MN 55121

P 800.288.2078
F 312.906.8879
E eligibility@alliedbenefit.com

Flexible Spending Account Enrollment Form

SECTION A EMPLOYER/EMPLOYEE INFORMATION

Employer Name	Group Number	Employer Location (if applicable)	Effective Date
Glenview School District #34	A04162A		

Employee Name	Employee SSN	Date of Birth

Address	City	State	Zip

Employee Email Address	Daytime Phone	Employee Gender
		Female ☐ Male ☐

SECTION B Election(s)

Use the table below to select your Flex benefits. The option for Limited Purpose Flex (LPFSA) is only available to employees participating in a HDHP plan. Please note that if you elect participation in the LPFSA below, you may elect to participate in the DCA but not the FSA.

	Annual/Mid Year Election Pledge	Divided By	# of Pay Periods: Annually / Mid Year	Equals	Deduction from each pay period
I elect to participate in the Health Flexible Spending Account		/		=	$
I elect to participate in the Dependent Care Account		/		=	$
I elect to participate in the Limited Purpose Flexible Spending Account		/		=	$
(Plan Year Example)	$3,050.00	/	24	=	Example $127.08

SECTION C Allied Flex Debit Card - SSN and DOB are required. Dependent must be over 17.

Please complete the information below for all dependents who should have an Allied Flex Debit Card.

Spouse Name:	Date of Birth:	SSN:	☐	Keep current dependent card active
			☐	Request new dependent debit card
Dependent Name:	Date of Birth:	SSN:	☐	Keep current dependent card active
			☐	Request new dependent debit card
Dependent Name:	Date of Birth:	SSN:	☐	Keep current dependent card active
			☐	Request new dependent debit card
Dependent Name:	Date of Birth:	SSN:	☐	Keep current dependent card active
			☐	Request new dependent debit card

SECTION D Direct Deposit

I would like to participate in Direct Deposit:

☐ **YES** ☐ **NO**

If yes, please complete the attached "Flex Direct Deposit Enrollment Form" and include a voided check.

☐ **I am currently participating in direct deposit. Please keep current banking information on file.**

SECTION E EMPLOYEE CERTIFICATION

I certify the above information is true and correct, and I authorize any premiums and Flexible Spending Account contributions, if applicable, to be paid on a pre-tax basis pursuant to Internal Revenue Code Section 125. I understand that any amounts which are not used for eligible expenses incurred during the Plan Year or Grace Period, will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the salary reduction(s) will be in effect for the Plan Year and cannot be revoked except as authorized by current Plan provisions and laws.

Employee Signature _____ **Date** _____

IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline participation.

Employee Signature _____ **Date** _____

Employer Use Only (Required for processing)

Employee's Flex Plan Effective Date	First Payroll Date	Payroll Cycle	I agree this form is correctly filled out by the Employee.
			HR Signature: