

**COREFLEX**  
**Flexible Benefits Election Form**

EMPLOYEE NAME \_\_\_\_\_ (Print) SSN: \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_ DAYTIME PHONE NO: \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DATE OF HIRE \_\_\_\_\_  
EMPLOYER NAME: Huron City School District PLAN YEAR: 2010

**You must choose to elect or decline for each program.**

**HEALTHCARE FLEXIBLE SPENDING PROGRAM**

I elect to participate in the Healthcare Flexible Spending Program. I direct and authorize my employer to reduce my annual salary for the above plan year by \$\_\_\_\_\_ and deposit this amount into my Healthcare Flexible Spending Account. (Annual Maximum: \$5,000)

\_\_\_\_\_ Annual Amount

\_\_\_\_\_ No: of Pay Periods

\_\_\_\_\_ Payroll Deduction

I elect not to participate in the Healthcare Flexible Spending Program.

**DEPENDENT CARE PROGRAM**

I elect to participate in the Dependent Care Program. I direct and authorize my employer to reduce my annual salary for the above plan year by \$\_\_\_\_\_ and deposit this amount into my Dependent Care Account. (Annual maximum: \$5,000 or \$2,500 for married filing separately)

\_\_\_\_\_ Annual Amount

\_\_\_\_\_ No: of Pay Periods

\_\_\_\_\_ Payroll Deduction

I elect not to participate in the Dependent Care Program.

**AUTHORIZATION**

I have read all the enrollment literature explaining these benefits. I understand that any contributions to the account can only be used to reimburse eligible expenses under the account and that I forfeit any funds remaining in my account at the end of the plan year after all claims have been filed. I further understand that I may not change my contributions during the plan year unless I have a Qualifying Event. Furthermore, my Social Security benefits may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll deductions as contributions to my Healthcare Flexible Spending Program and/or Dependent Care Program as indicated above.

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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