Section 125 Cafeteria Plan Enrollment Form

San Antonio Christian Schools

September 1, 2013 to August 31, 2014

Part 1: Personal Information

First Name	**Last Name**	**SSN** __ __ __ __ __ __ __ __ __

Mailing Address	**City, State**	**Zip code**

Physical Address (if different than mailing)	**Date of Birth** ______ ______ ______
Home phone #	**Work Phone#**

Email Address: _____________________________________ ____________________________

Important: By providing your email address, you are agreeing to allow SBS to send account transaction information to you via email including transaction information, account balances and plan year reminders.

Part 2: Benefit Election — Effective Date _____ ______ _____

☐ **Medical Spending Account** (Maximum annual deduction is $2,500)

- Pay Period Election of $_______ x __ pay periods = Annual Election of $_________

☐ **Dependent Care Spending Account (Child or Adult Day Care)**
(Maximum annual deduction is $5,000; or $2,500 if married but filing single.)

- Pay Period Election of $_______ x __ pay periods = Annual Election of $_________

What rules should I know about?

1. Expenses must be prospective – you can use this year's FSA funds to pay for this plan year's expenses but you can't use this plan year's funds to pay for expenses incurred before the plan year began.
2. Receipts – be sure to keep copies of all receipts; including those for services paid for with the Benefits Card.
3. Benefit Card transactions – some transactions will require that you send a copy of your receipt after your purchases. SBS will notify you when it's time to send a copy.
4. Use or Lose Rule – any amount that is left in the account at the end of the plan year grace period that is unclaimed will be forfeited. Plan carefully and conservatively in your estimates.
5. Run out period (timely filing deadline) – there is a 90 day deadline for filing all claims. This deadline applies either at the end of the plan year grace period or from your termination date.

☐ I waive participation in the Medical Spending Account
☐ I waive participation in the Dependent Care Spending Account

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San Antonio Christian Schools	**Employee Name:**	**SSN#**

Part 3: Request for Benefit Card

By requesting a Flex Benefit Card for either the employee or dependents, you are stating that you have read, understand and agree to the terms of the Benefit Card Agreement provided to you. ***Flex Benefit Cards are good for three years. Do not discard your card at the end of the plan year to avoid paying a replacement card fee.***

New Cardholders	Existing Cardholders (**Note** – all previously issued cards will be reactivated at renewal. If you no longer want your dependent to have a card you must notify our office. If you would like to request a replacement card or request a card for a new dependent please check the appropriate box below.)
☐ Request a Flex Benefit Card for myself **(There is no fee for the initial card)**	☐ Request a replacement Flex Benefit Card for myself **(A nominal fee of $2.50 is deducted from the employee's FSA account for reorder due to lost/discarded card.)**
☐ Request an additional card for the following dependent(s): **(A nominal fee of $2.50 per card is deducted from the employee's FSA account.)**	☐ Request a replacement or new card for the following dependent(s): **(A nominal fee of $2.50 per card is deducted from the employee's FSA account.)**
Name of dependent (18 yrs or older): Relationship: Spouse or Child (circle one)	Name of dependent (18 yrs or older): Relationship: Spouse or Child (circle one)
SSN: — — — — — — — — —	SSN: — — — — — — — — —

Part 4: RELEASE OF INFORMATION & REQUIRED AUTHORIZATION
(All Participants Must Complete)

Please indicate by checking either YES or NO, whether you would like to authorize parties other than yourself to obtain general and/or individual FSA account transaction information. If you check the YES box, please provide the name of the authorized individual and their relationship to you in the space provided. ***Please Note:*** If you check the NO box, then we will not release any information, even if the individual requesting information is an existing cardholder. (You maintain the right to revoke this authorization at any time.)

I AUTHORIZE SBS TO RELEASE INFORMATION REGARDING INDIVIDUAL FSA ACCOUNT TRANSACTIONS:
YES _____ NO _____ ***(See note above)***

Authorized Individual:	Relationship to Employee:

I have read and understand the explanation I have received regarding my options under the San Antonio Christian Schools Section 125 Flexible Benefit Cafeteria Plan. I understand I have the right to have my employer redirect my salary and apply this amount toward the purchase of the Premium Payment Benefits and/or the Reimbursement Accounts which I have elected to participate in. Elections for eligible benefits will be purchased on a pre-tax basis unless otherwise noted although this plan may allow you to opt out and pay for these elections on an after-tax basis (Medical and Dependent Care Accounts are always pre-taxed). Please consult your Summary Plan Description for more information. I acknowledge that my pre-tax elections, including the Medical and Dependent Care Spending accounts, *cannot* be changed once the plan year of *September 1, 2013 to August 31, 2014* has begun unless there is a change in family status. A change in family status includes: changes in marital status, changes regarding dependents, changes in employment status, changes in residence or work site, or a dependent ceasing to satisfy the eligibility conditions for coverage. I understand that the IRS requires that I retain ALL receipts for expenses reimbursed through this plan and that the Plan Administrator or the IRS may request to review these receipts.

☐ *I authorize my election for qualified premium benefits to be taken on a pre-tax basis. (FSA elections will be pre-taxed)*
☐ *I do not authorize my election for qualified premium benefits to be taken on a pre-tax basis.(FSA elections will be pre-taxed)*

Employee Signature:	Date: