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FLEXIBLE SPENDING ACCOUNT
ENROLLMENT FORM

NORTH KITSAP SCHOOL DISTRICT ______________________________ Mo Day Year
Employer | Employer Telephone | Eligibility Date

______________________________ - - ______ Mo Day Year
Employee Last Name | First Name | MI | Social Security Number | Birthdate

____
Employee Mailing Address (Street) (City) (State) (Zip)

Employee Phone ___-___-___________

Primary Beneficiary ______________________ Relationship ______________________

Payroll Deducted Group Insurance Premiums

Your group insurance premium contribution will be pre-taxed unless you check the "No" line below and return the completed form by the enrollment deadline date.

___ **No**

I request the following amounts(s) to be reduced per pay per

Do you want to participate?			Per Pay Period	Annual
Yes	No	**Unreimbursed Health-Related Expenses**	$ ________	$ ________
Yes	No	**Dependent Care Expenses**	$ ________	$ ________
TOTAL AUTHORIZED REDUCTIONS			$ ________	$ ________

I hereby certify the above information to be correct and true to the best of my knowledge and that the children on whom I will be claiming dependent expenses or child care, either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provision and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment. I also understand that the above reductions may correspondingly reduce my future Social Security Benefits.

PREMIUM COMPLETION AGREEMENT

I am agreeing to participate in the Unreimbursed Health Expense account for the entire Plan Year. I understand that if my employment were terminated the remaining monthly premiums will be taken from my final paycheck on a pre-tax basis; or in the alternative agree to reimburse my employer (on a monthly basis) with after-tax dollars. If my final paycheck does not cover the remaining contributions I agree to reimburse my employer the remaining balance. I further understand that I have through the end of the Plan Year to incur eligible expenses, and may request reimbursement through the end of the normal run-out period as described in the Summary Plan Description.

Signature ______________________________ Date ______________________