Lincoln Benefit Trust
Self Funded Health Benefits

FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION FORM

Plan Year 2024 (July 1, 2024 – June 30, 2025)

All Forms are due by **Friday, April 19, 2024.**

Please see our FAQ on the Dover SD website under Staff Resources for more information on Flexible Spending Accounts.

☐ I want to re-enroll in the FSA Program for 2024-25.

Please complete Sections 2, 3 and 4

☐ I do **not** want to re-enroll in the FSA program for 2024-2025.

Please sign below:

_____

Print Name: _____

To view your current FSA election per pay amount, please view your paycheck on Skyward and look for the deduction code "Flex Spending" or "Dep Care FSA".

Section 2

Health Care FSA Election ($3,200 max for 12-month period):

I elect to contribute a total of **$ _____** for the plan year to the **Health Care FSA** Plan, which will be deducted from my paycheck in equal installments from my July 1, 2024 through June 30, 2025.

Please see label above for your current total FSA plan year election.

** You may contact Heather Thomas if you would like assistance in calculating your per pay amount based on your total plan year election.*

Dependent Care FSA Election ($5,000 max per household for 12-month period):

Reminder: Your dependent care FSA helps you pay for expenses incurred to care for children or other individuals while you work.

I elect to contribute a total of **$_____** for the plan year to the **Dependent Care FSA** Plan, which will be deducted from my paycheck in equal installments from July 1, 2024 through June 30, 2025.

Please see label above for your current total DCare plan year election.

** You may contact Heather Thomas if you would like assistance in calculating your per pay amount based on your total plan year election.*

Please complete the back

Section 3

Dependents Covered by the either the Healthcare FSA or Dependent Care FSA Plan:
(use additional page (if applicable) to list all additional eligible dependents)

Name	Relationship to Employee	Date of Birth

Section 4

I understand that:

- I cannot change or revoke this election during the Plan Year unless I have a change in family status (divorce, marriage, death, birth or adoption of a child) or some other event occurs pursuant to which the Employer permits a change in election.
- Prior to the first day of each subsequent Plan Year, I will be offered the opportunity to re-enroll.
- I understand that salary reductions may not be carried over into future Plan Years.
- The Employer may reduce or change this Agreement if necessary to satisfy provisions of the Internal Revenue Code.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S HEALTH CARE FLEXIBLE BENEFIT PLAN AS AMENDED FROM TIME TO TIME AND SHALL BE GOVERNED BY APPLICABLE LAWS.

I have read and agree to the terms and conditions shown above and agree to the salary reductions described above.

_____ _____

Employee's Signature Date

Any person who knowingly and with intent to defraud any insurance company or other person; files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.