San Diego Unified
SCHOOL DISTRICT

FINANCE DIVISION
Employee Benefits Department
P - 619.725.8130
F - 619.725.8132

2019 FLEXIBLE SPENDING ACCOUNT ELECTION FORM

Last Name: **First Name:** **Employee ID#:**

Address: **Phone: ( )**

City: **State:** **Zip:**

☐ ***HEALTH CARE FSA --*** **$2,650** Annual maximum per employee

I wish to redirect a total of $____________for the 2019 plan year ($___________ per pay period, **excluding the July and August pay periods**) to my Health Care FSA.

☐ ***DEPENDENT CARE FSA --*** **$5,000** Annual maximum per family ($2,500 maximum if married filing separately)

I wish to redirect a total of $___________ for the 2019 plan year ($____________ per pay period, **excluding the July and August pay periods**) to my Dependent Care FSA. I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, the annual maximum is $2,500.

☐ ***FLEX DEBIT CARD*** **(for Health FSA only) --** I am interested in receiving a Flex Debit Card.

By checking this box, I understand that American Fidelity will send me a Flex Debit Card. Flex debit cards can also be requested for spouse and dependents over the age of 18. To request additional debit cards for eligible dependents, please contact American Fidelity directly at flex@americanfidelity.com or call 800.662.1113.

Authorization — *Please Read Carefully*

I request and authorize the District to reduce the amount of salary payments due me by the above amount(s) and to divert the amount(s) of such reduction(s) to my FSA account(s). I agree that the District shall in no way be liable to me or my successors for any monetary damages which might arise from the federal or state tax consequences of my participation in this plan and consistent therewith. I further agree to save and hold harmless the District from any such monetary damages.

I understand that a reimbursable expense cannot be claimed under both an FSA and the Health Reimbursement Account (HRA) issued with the UnitedHealthcare SignatureValue Alliance HMO medical plan.

I understand that the choices I have indicated above must remain in effect for the entire 2019 plan year unless I have an eligible family status change. Eligible family status changes include: change in employee's legal marital status; change in the number of tax dependents; termination or commencement of employment by employee, spouse or dependent; change in work schedule (summer recess and intersession periods are not considered family status changes); dependent satisfies (or ceases to satisfy) dependent eligibility requirements; change in residence or worksite of employee, spouse, or dependent.

I understand that any unused balances in either the Health Care or Dependent Care account at the end of the plan year shall be forfeited.

____ ______________________

Signature of Employee Date

FOR DISTRICT USE ONLY: ***Coverage Effective Date: 01/01/2019*** ***No. of Pay Periods:10***

PLEASE RETURN TO:

EMPLOYEE BENEFITS DEPARTMENT
Eugene Brucker Education Center
Room 1150-A

Originals are not needed. Completed form may be sent to: **employeebenefits@sandi.net**