

Enrollment Form: Flexible Spending Account



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EMPLOYEE INFORMATION

Eugene School District 4J _____
Employer _____ Eligibility Date (mm/dd/yy) _____

Employee Last Name _____ First Name _____ Middle Initial _____ Social Security Number _____

Employee Mailing Address (Street) _____ (City) _____ (State) _____ (ZIP) _____

Home Phone _____ Work Phone _____

E-mail _____

ACCOUNT INFORMATION

Beneficiary*: _____ Relationship: _____

*Please designate someone over the age of 18 to be the beneficiary for your account. This person will be responsible for submitting claims in the event you are not physically able to do so. The beneficiary does not need to be related to you.

I request the following amounts to be reduced from my paycheck:

| | Per Pay Period Amount | Annual Amount | |
|---|-----------------------|---------------|---|
| Dependent Care Expenses | \$ _____ | \$ _____ | <input type="checkbox"/> Not applicable |
| Unreimbursed Eligible Health-Related Expenses | \$ _____ | \$ _____ | <input type="checkbox"/> Not applicable |
| TOTAL AUTHORIZED REDUCTIONS | \$ _____ | \$ _____ | |

AUTHORIZATION

I hereby certify the above information to be correct and true to the best of my knowledge, and that the children for whom I will be claiming dependent or childcare expenses 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 provisions and tax laws. I further understand that the flexible compensation reductions will be in effect for the Plan Year and cannot be revoked unless I experience a qualified change in status. I also understand that the above reductions may correspondingly reduce my future Social Security benefits.

Signature: _____ Date: _____

Participant: Return original to your employer and retain a copy for your records. **Employer:** please forward a copy to Manley.