Wyandotte Public Schools

GROUP RESOURCES®
Employee Benefit Concepts, Inc.
a Group Resources® Company

REIMBURSEMENT ACCOUNT ELECTION FORM

Plan Year January 1, 2022 - December 31, 2022

Employee Name: _____ Social Security Number _____
(Please Print)

Address: _____
Street City State Zip

Employee Number_____ Date of Birth_____/_____/_____ Hire Date: _____

Email address (required) _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Please note the debit card annual service fee is $15.00 per family. If you choose to use the debit card service for the 2022 Plan Year, your Medical Reimbursement Account will be decreased $15.00 for the cost of the card.

Do you want to use the debit card service for 2022? Please Circle Yes No

If yes, please note the expiration date of your current debit card. **If the expiration date is December 31, 2021 or if you are a new user, you may request the Take Care Debit Card on the www.myflexonline.com website** once you receive your confirmation letter in the mail. If you circle "no" or do not circle either option above, your debit card will be suspended on December 31, 2021.

REIMBURSEMENT ACCOUNTS

	Number of Pays	Annual Amount		Reduction Per Pay
	Please Circle			
A. Uninsured Health Care	21 or 26 Pays	$_____	($ 2,750 Max $60 Min)	$_____
B. Dependent Care	21 or 26 Pays	$_____	($ 5,000 Max $60 Min)	$_____

I UNDERSTAND THAT I CANNOT CHANGE MY ELECTION AND PAY REDUCTIONS UNLESS I EXPERIENCE A CHANGE IN MY FAMILY STATUS. My employer and I agree that my salary will be reduced by the amount(s) listed above for the benefit option(s) I have elected under the Flexible Spending Plan. I hereby acknowledge that I have read the Understanding of Agreements on the reverse side of this form.

Further, I hereby consent to the use of my personally identifiable information, and or my dependent(s)' information, which I have voluntarily provided on this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, or my dependents' behalf, for the sole use of providing benefits, services or any information I have requested.

This agreement is subject to the terms of the Wyandotte Public Schools Flexible Compensation Plan, as amended from time to time, and revokes any prior election and compensation reduction agreement relating to such plan.

_____ Date _____
Employee Signature

_____ Date_____
Employer Signature

RETURN COMPLETED ENROLLMENT FORM TO THE BUSINESS OFFICE BY 12/3/2021