FREEPORT SCHOOL DISTRICT
2024 FLEXIBLE SPENDING PLAN ELECTION FORM

SECTION I. EMPLOYEE INFORMATION

Employee – Last Name	First Name	Middle Initial	Date of Birth	Social Security Number

Street Address	City	State	Zip Code
Email			

SECTION II. FLEXIBLE SPENDING ACCOUNT AGREEMENT

Type of Election: ☐ **2024 Annual Election** ☐ New Hire ☐ Family Status Change* (see below)

*Explanation for change in Family Status: ___________________________

Effective Date of this election: __________ Pay periods per year: ☐ 24 per year ☐ 18 per year ☐ Other ________

I hereby elect to have may salary reduced and a corresponding amount credited to my account in the Plan. Any previous election and compensation reduction agreement under the Flexible Spending Account relating to the same benefits is hereby revoked.

I agree to have my salary reduced as follows:

☐ I wish to participate in a ***Medical Flexible Spending Account***
I hereby authorize my employer to reduce my yearly earnings in the amount of $_____________ per year to be deducted in equal amounts ($__________ per pay period) from each pay period throughout the year, and credited to my flexible spending account for eligible medical, dental, and vision expenses. Eligible expenses include those which the health plan does not cover (i.e. deductible, co-payments, etc) and are limited to those specified as eligible by IRS regulations. I understand that I will need to submit each claim, attaching my bill, receipt, or EOB, to Northern Illinois Health Plan in order to receive reimbursement for eligible expenses except as otherwise agreed to below.

☐ I wish to participate in a ***Dependent Care Flexible Spending Account***
I hereby authorize my employer to reduce my yearly earnings in the amount of $_____________ per year to be deducted in equal amounts ($___________ per pay period) from each pay period throughout the year, and credited to my flexible spending account for eligible dependent care (child or elder care) expenses. Eligible expenses are limited to those specified as eligible by IRS regulations. I understand I will need to submit a claim with proof of payment to Northern Illinois Health Plan in order to receive reimbursement for eligible expenses.

****Direct Deposit Available – Please refer to the back of this form****

Employee's Signature	Date	Approved by FSD	Date

SECTION III. DEBIT CARD

Due to the integration of the PrePaid Debit Cards for the Medical Flexible Spending Accounts, the option of Automatic Rollover Reimbursement is no longer available.

Your 2024 debit cards are called "**Prepaid Debit Cards**" **ALL** **new** 2024 Medical Flexible Spending Account members will receive two (2) new Prepaid Debit Card *(Your Prepaid Debit Card is good for 3 years from the original date of issue).* Please note that you *may* be asked to submit receipts to verify that your debit card purchases are flexible spending eligible under the IRS Guidelines.

If you choose not to utilize your 2024 Medical Flexible Spending Account by using your Prepaid Debit Card, you may submit receipts to NIHP at NIHPCustomerService@nihp.com, mail to PO Box 880, Freeport, IL 61032 or Fax to 815-599-7059. You may also upload receipts using our mobile app.

My signature verifies that all transactions made with my Prepaid Debit Card are eligible expenses for which I am liable for and that these expenses are not eligible for reimbursement/payment under any other source. I agree that when required by IRS regulations, Northern Illinois Health Plan may require me to submit receipts for purchases made with my Prepaid Debit Card. I also understand that I must obtain all receipts for purchases made.

____ ______________
Employee's Signature Date