Election to Participate
Flexible Spending Plan
Lafayette Parish School System

Employee Name: ________________________ Social Security #: _____________________

Employee Address: _____________________ Plan Year: Jan. 1, _____ To Dec. 31, _____

____________________________ School/Dept: _________________________

Daytime Phone: ________________________ Email: ______________________________

Election of Benefits with Salary Reduction

I hereby make the following election regarding the benefits available to me under the Flexible Spending Account Benefits Plan. I am further making an election to make taxable compensation reduced by an amount equal to the value of the benefits specified below, such amount to be deducted in approximately equal sums from my regular paychecks during the coming Plan Year specified above.

I have been provided a copy of the Plan Information Summary by my Employer that is operating pursuant to the state laws of Louisiana.

I elect to receive

Medical Reimbursement $ _____________________ Annually

Dependent Care Reimbursement $ _____________________ Annually

I understand that

Participation in a medical reimbursement account may prohibit a participant and/or their spouse from making qualified contributions to a Health Savings Account (HSA).

I cannot change or revoke this Agreement at any time during the Plan Year unless I have a change in status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Plan Administrator determines will permit a change or revocation).

If one of the above events occurs and I desire to make consistent changes to my benefit elections, I must inform the Plan Administrator of my new election within 30 days of the occurrence. All changes are made prospectively from the date that the Administrator receives a properly completed and signed “Change of Status” form. These forms will be available in the Insurance Department or on the website.

This agreement will automatically terminate if the Plan is terminated or discontinued or if I cease to receive compensation from my Employer.

The Plan Administrator may reduce, cancel or otherwise modify this Agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this Agreement shall be in addition to any other reductions under other agreements or benefit plans.

Any amounts that are not used during the Plan Year to provide benefits will be forfeited.

Only claims incurred January 1 through December 31 of the Plan Year specified above are eligible for reimbursement under this plan.

Claims must be received by the Plan Administrator by 4:30 p.m. on March 31 next following the end of the Plan Year in which the eligible expenses were incurred.

I hereby elect to participate in the Flexible Spending Account Benefit Plan and receive the benefits designated above.

Signature: _________________________________ Date: ______________________

Website for account access:

www.advancedadministrators.com
Employer Code: 93200149