



Employee Enrollment Form- Flexible Spending Accounts (FSA)
July 1, 2025 – June 30, 2026

Employee Number: Social Security Number:
Employee Name:
Mailing Address:
City: State: Zip:
Primary Phone No: Email Address:
Date of Birth: Date of Hire:

FLEXIBLE SPENDING ACCOUNTS:

I hereby elect to participate in the Flexible Spending Accounts (FSA) July 1, 2025 – June 30, 2026

This is a use it or lose it benefit – No rollovers are allowed

Please mark your selection by the amount you would like deducted PER PAY

Health Care FSA (\$2,500.00 limit) \$ per pay \$ Total Per Year
Dependent Care** FSA (\$5,000.00 limit) \$ per pay \$ Total Per Year

(**Day care expenses incurred during employment hours)

MY PAY SCHEDULE IS:

- City/G&E bi-weekly (26) School bi-weekly (26) (Teachers/Staff paid 12 months a year)
Athenaeum School bi-weekly (22) (Aides/Food Service/Registered Behavior Technician)

AUTHORIZATION & ACKNOWLEDGEMENT:

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

The \$37.20 per year non-refundable Administrative Fee will be a separate deduction taken from my payroll.

You will receive one TASC Card to use for your benefit account(s). You may request one additional card free of charge for your Spouse or Dependent. Cards are mailed to your home address 7-10 days after your enrollment has been processed.

Spouse/Dependent Name:

Employee Signature

Date