PayPlans & Benefits
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2017- 2018 Flexible Spending Account (FSA) Authorization

Dighton-Rehoboth Regional School District **Effective Date:**_____

Name: _____ Date of Birth: _____
First Middle Initial Last

Address:_____
Street City State Zip Code

Home Email:_____ Home/Cell Phone:_____

Hire Date: _____ Marital Status: _____ Social Security Number: _____ Male ☐ Female ☐

Dependents to be covered:

First and Last Name	Birth Date	Relationship to Employee
First and Last Name	Birth Date	Relationship to Employee
First and Last Name	Birth Date	Relationship to Employee

I have chosen to participate in the following programs, which are offered on a pre-tax basis.

☐ Medical Reimbursement Plan Monthly $_____ / Per Plan Year $_____(Limit $1,500)

☐ Dependent Care Reimbursement Plan Monthly $_____ / Per Plan Year $_____ (Limit $5,000)
The DCFSA maximum annual election is $5,000.00 per household or $2,500.00 if married, filing separately

Reimbursements: □ check or □ direct deposit (must complete direct deposit form on reverse side)

Annual Reduction: You are reducing your annual compensation to pay for eligible health costs that may not be covered by your benefit plan(s). In essence, you will be paying for these expenses on a pre-tax basis. This is a voluntary plan and the amount you designate as your Annual Salary Reduction should be conservative. Remember, if you do not utilize the funds during the Plan Year (and grace period, if any), you lose them.

Salary Reduction Agreement: I understand the Explanation of Benefits detailing Dighton Rehoboth Regional School District's Flexible Spending Account (FSA). With this Authorization, I am directing Dighton Rehoboth Regional School District to reduce my annual compensation by the Total Per Plan Year amount shown and reimburse me upon submitting eligible receipts. By reducing my annual compensation, I am essentially paying for uncovered benefits with pre-tax dollars. I understand that this annual reduction is irrevocable and cannot be changed unless a "Change in Life Status" is experienced. In addition, I further understand that you can participate in either or both of these accounts; however, the funds are separate and you cannot transfer from one account to another. As of January 1, 2011, some of the items previously allowed are ineligible for reimbursement through an FSA plan due to changes with Healthcare Reform.

_____ _____ / _____ / _____
Employee Signature Date

PayPlans & Benefits
P.O. Box 730
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Phone (508) 457-0333

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Fax (508) 457-9994

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Direct Deposit Authorization Agreement

I hereby authorize on this _____ day of _____, 20_____ PayPlans & Benefits to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my Checking or Savings accounts at the depository indicated below:

_____ Financial Institution

_____ Branch

_____ City, State, Zip

_____ Phone Number

_____ Bank Routing Number or ABA Number

Account

Account Number _____ Account Type ☐ Checking ☐ Savings

This authorization will remain in effect until;

a) I notify my Bank and the above named Company in writing to terminate this agreement and give the Bank and the above named Company reasonable time to terminate the Agreement,

b) The Bank and/or the above named Company have sent me five (5) business days advance written notice of the Bank's and/or Company's termination of this Agreement

Print Employee Name _____

Employee's home e-mail address _____

Social Security Number _____

Employee Signature _____

Date _____

Please attach a **voided personal check** to this authorization form for verification of all checking account information. Please be advised that is takes a minimum of two (2) weeks for your direct deposit to go into effect.

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