

NIAGARA-WHEATFIELD CENTRAL SCHOOL DISTRICT

TEACHERS' FLEXIBLE BENEFITS PROGRAM 2008-2009 ENROLLMENT FORM

EMPLOYEE INFORMATION (Please Print)																								
Employee Name:			Employee Social Security Number:																					
Address:		City:		State:	Zip Code:																			
Email Address:			Home Telephone:		Work Telephone:																			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; padding: 2px;">Birth Date</th> <th style="text-align: left; padding: 2px;">Gender:</th> <th style="text-align: left; padding: 2px;">Marital Status:</th> <th style="text-align: left; padding: 2px;">Effective Date: Month/Day/Year</th> <th colspan="2" style="text-align: left; padding: 2px;">Employer Signature:</th> </tr> <tr> <td style="padding: 2px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 2px;">Month</td> <td style="width: 30%; padding: 2px;">Day</td> <td style="width: 40%; padding: 2px;">Year</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table> </td> <td style="padding: 2px;"> <input type="checkbox"/> Male <input type="checkbox"/> Female </td> <td style="padding: 2px;"> <input type="checkbox"/> Single <input type="checkbox"/> Married </td> <td style="padding: 2px;"> PAYROLL USE ONLY ___ / ___ / ___ </td> <td colspan="2" style="padding: 2px; height: 40px;"></td> </tr> </table>	Birth Date	Gender:	Marital Status:	Effective Date: Month/Day/Year	Employer Signature:		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 2px;">Month</td> <td style="width: 30%; padding: 2px;">Day</td> <td style="width: 40%; padding: 2px;">Year</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>	Month	Day	Year				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	PAYROLL USE ONLY ___ / ___ / ___								
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DEPENDENTS (Please Print)			
Name	Relationship	Birth Date	Social Security #
	spouse		

IMPORTANT:

By enrolling in the Cafeteria/Flexible Benefits Program I understand that:

- ◇ I will be paid from the reallocation account(s) upon submission of properly prepared claim forms.
- ◇ I may not change my election during the Plan Year except for a change in family status.
- ◇ I may not transfer money between options (Health and Dependent Care).
- ◇ I will forfeit any balance remaining 90 days after year end.

- I elect to have my out-of-pocket BCBS WNY automatically paid through the Flexible Spending Account.
- I elect to have my Flexible Benefits check direct deposited into my checking account. (Please fill out the Direct Deposit Authorization form)

EMPLOYEE ELECTIONS							
Benefit Election Options	Participation		Salary Reduction Amount				
Medical Expenses Maximum of \$4,000 per plan year.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	\$ _____ per pay period	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="font-size: 8px; text-align: center;">No. of pay periods during the Plan Year.</td> <td style="text-align: center; font-size: 18px; font-weight: bold;">20</td> </tr> </table>	No. of pay periods during the Plan Year.	20	\$ _____ per plan year
No. of pay periods during the Plan Year.	20						
Dependent Care Expenses Maximum of \$5,000 per plan year. (\$2,500 if married filing separately)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	\$ _____ per pay period	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="font-size: 8px; text-align: center;">No. of pay periods during the Plan Year.</td> <td style="text-align: center; font-size: 18px; font-weight: bold;">20</td> </tr> </table>	No. of pay periods during the Plan Year.	20	\$ _____ per plan year
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Adoption Assistance Plan Maximum of \$10,390 per plan year.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	\$ _____ per pay period	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="font-size: 8px; text-align: center;">No. of pay periods during the Plan Year.</td> <td style="text-align: center; font-size: 18px; font-weight: bold;">20</td> </tr> </table>	No. of pay periods during the Plan Year.	20	\$ _____ per plan year
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NOTE: Amounts allocated to Health Care and/or Dependent Care are pre-tax expenditures. New employees; if you enroll after the beginning of the Plan Year, pay period allocation amounts will be prorated according to the length of time remaining in the plan year. If an annual amount is not evenly divisible by the number of pay periods, the pay period amount will be rounded downward.

YOU MUST COMPLETE AND SUBMIT FEDERAL FORM W-10 FOR EACH CHILD CARE PROVIDER.

Employee Signature: _____

Date: _____