One Dodge Street
North Greenbush, NY 12198
(518) 283-8500

Health Reimbursement Account

EMPLOYEE/EMPLOYER ELECTION FORM

COMPANY/CLIENT NAME **Ichabod Crane CSD**		
EMPLOYEE NAME	DATE OF BIRTH / /	DATE OF HIRE / /
SOCIAL SECURITY NUMBER	EMPLOYEE PHONE NUMBER	
ADDRESS: STREET, CITY, STATE, ZIP		
EMAIL ADDRESS **(REQUIRED)**		

ELECTION:

First payroll date _____ (Employer - Office Use Only)

Per Health Care Reform, effective January 1, 2011 over the counter medications will no longer be an eligible item if not accompanied by a prescription.

ACCOUNT	ANNUAL Employer Contribution
Unreimbursed Medical Account	

DEPENDENT ENROLLMENT * List ALL dependents that can/will be eligible for reimbursements under the HRA. **ONLY Dependents Enrolled under the Group Health Plan are Eligible for HRA Reimbursements.**

Dependent Name	Date of Birth	SSN	Relationship

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I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning _7_/_1_/_2016_, and ending _6_/_30_/_2017_. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked and I understand that election is required annually to participate. As a participant, I understand that:

- I cannot change or revoke this agreement at any date prior to the next plan year, unless I have a change in my family status as set forth in the Adoption Agreement and Summary Plan Description. Prior to my next Plan Year I will be offered the opportunity to change my benefit election for the following year.
- My pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected, continuing for each succeeding pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that change.
- The Plan Administrator may change the amount of my reduction or otherwise modify this agreement, if he believes it is required to satisfy provisions of the Internal Revenue Code.
- The amount of my compensation reduction will be credited to the appropriate reimbursement account on my employer's books for payment of eligible expenses incurred within the plan year.
- Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount.

PLEASE NOTE:

ONLY Dependents Enrolled under the Group Health Plan are Eligible for HRA Reimbursements

CHANGES/TERMINATIONS (Employer – Office Use Only)

Date of Event: ____/____/____
First paycheck date that change will be processed: ____/____/____.

___ Marriage/Divorce
___ Birth/Death of Spouse or Dependent
___ Spouse's employment commenced/terminated
___ Status change from full-time to part-time or part-time to full-time by employee or spouse
___ Unpaid leave of absence by employee or spouse
___ Open Enrollment
___ Employment Termination

Employee Signature_____ Date_____

Employer Signature _____ Date _____

HUMAN RESOURCES – OFFICE USE ONLY
(ALL FIELDS REQUIRED)

Highly Compensated ❑ Y ❑ N

Key Employee ❑ Y ❑ N

Officer ❑ Y ❑ N

Spouse or Dependent of Owner ❑ Y ❑ N

More than 5% Owner ❑ Y ❑ N

More than 1% owner with salary greater than $150,000 ❑ Y ❑ N