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## NEWTOWN BOARD OF EDUCATION FLEX ENROLLMENT FORM

EMPLOYEE INFORMATION	
NAME	SOCIAL SECURITY NUMBER
HOME ADDRESS	DATE OF BIRTH
CITY, STATE, ZIP CODE	DATE OF HIRE
E MAIL ADDRESS:	

Marital Status: Married  Single  Divorced  Widowed

Benefits Effective 7/1/2024 Pay Period Effective Date 7/12/2024 Number of Pay Periods     

Please Check One:: New Enrollee  Change  Termination

**SECTION 125 MEDICAL REIMBURSEMENT ACCOUNT** Yes  No

Per Pay Amount: \_\_\_\_\_ Annual Amount **(\$1,500.00 Maximum)** \_\_\_\_\_

**SECTION 129 DEPENDENT DAY CARE REIMBURSEMENT** Yes  No

Per Pay Amount: \_\_\_\_\_ Annual Amount **(\$5,000 Maximum)** \_\_\_\_\_

**ADMINISTRATION FEE** *(For Reimbursement Accounts only)*

Annual Amount \$ 60

**THIS FORM REQUIRES YOUR SIGNATURE. PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM.**

**PLEASE RETURN THE COMPLETED FORM TO DENISE HORNYAK IN THE CENTRAL OFFICE**

I understand that:

- ◆ I CANNOT CHANGE OR REVOKE ANY OF MY ELECTIONS or this compensation reduction agreement at any time during the plan year unless I have an IRS defined change in status: marriage, divorce, legal separation or annulment, a judgment, decree or court order resulting from divorce legal separation or annulment, death of a dependent, birth, adoption or placement for adoption or change in my or my spouse's or my dependent's employment status resulting in a reduction or increase in hours, or a change in the place of residence or work of the participants spouse or dependent. No change is allowed unless eligibility for benefits is either lost or gained. The election change must be consistent with the status change. THE NEW ELECTION MUST BE FILED WITHIN 30 CALENDAR DAYS OF THE OCCURRENCE OF THE FAMILY STATUS CHANGE EVENT.
- ◆ The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event they believe 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 reduction under other agreements or benefit programs maintained by my Employer.
- ◆ If you are currently enrolled, your flex contribution will **not continue unless you complete, sign and return a new form.**
- ◆ My Social Security benefits may be reduced because the tax-free benefits under the Plan reduce the amount of contributions that are made to the Federal Social Security System.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S FLEXIBLE SPENDING ACCOUNT PLAN, AS AMENDED FROM TIME TO TIME, SHALL BE COVERED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.

**STATEMENT OF ENROLLMENT:**

PLEASE ENROLL ME IN THE FLEXIBLE SPENDING ACCOUNT PLAN(S) I HAVE SELECTED ON THE FRONT OF THIS FORM AND MAKE THE NECESSARY PAYROLL ADJUSTMENTS. I HAVE READ AND UNDERSTAND THE ENROLLMENT MATERIAL.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**STATEMENT OF DECLINATION:**

I UNDERSTAND I WILL NOT BE ENROLLED IN ANY OPTION WHERE I HAVE CHECKED "NO" ON THE FRONT OF THIS FORM. I HAVE READ AND UNDERSTAND THE ENROLLMENT MATERIAL.

SIGNATURE: : \_\_\_\_\_ DATE: \_\_\_\_\_

**ACCEPTED AND AGREED TO BY:**

\_\_\_\_\_  
**EMPLOYER'S AUTHORIZATION**

**NEWTOWN BOARD OF EDUCATION**