For Contract Employees Only

EMPLOYEE SPENDING ACCOUNT ENROLLMENT FORM - 2025

Academic ____ Classified ____

EMPLOYER NAME: San Diego Community College District GROUP NUMBER: BB1055

EMPLOYEE NAME LAST	FIRST	MI	SEX	PeopleSoft ID#: / SS#: DO NOT ENTER
			☐ M ☐ F	

EMPLOYEE ADDRESS: ☐ Please check if this is a change in address

Street

City State Zip

Email Address Fax Number (for return correspondence)

Home Phone Work Phone

DATE OF BIRTH: ____/____/____

DATE OF HIRE: ____/____/____

☐ SEND ME A NEW DEBIT CARD

☐ **SEND ME A DEBIT CARD FOR MY DEPENDENT SPOUSE/ PARTNER OR CHILD**

PLEASE COMPLETE

I ELECT THE FOLLOWING:		Monthly Deduction		Annual Election: Annual **Amount**	Annual Election: Maximum
Healthcare Account:	☐ Yes ☐ No	$ _____		$ _____	$ 3,200 Plan Year[1]
Dependent Care Account	☐ Yes ☐ No	$ _____		$ _____	$ 5,000 Calendar Year

Pre-Tax Premium Deductions: health insurance premiums, and all other eligible insurance premiums, will be excluded from taxable income. The employer will automatically apply pre-taxation of these insurance premiums unless you specifically decline the option. If you do not wish to have your insurance premiums pre-taxed, you must notify Human Resources during open enrollment.

Family Status Change? Yes ____ Type: _____ Effective Date: _____

Married? Yes ____ Name of Spouse: _____ Date of Birth: _____

Beneficiary: _____ (In the event of your death, claims payment designation)

Pay Status (check one): 10-Month Pay____ 11-Month Pay____ 12-Month Pay____

AUTHORIZATION

By signing this form, I certify the following:
1) I have read the information provided to me on Flexible Benefits. 2) The above information is correct and I authorize the salary reductions as I have indicated. 3) I understand that any amounts remaining in my Health and/or Dependent Care Account(s) – not used for eligible expenses incurred during the Plan Year, including the grace period, may not be carried forward, according to Plan provisions and pre-tax laws. 4) I understand that the elected salary reduction(s) will remain in effect for the Plan Year and can only be changed if I experience a change in my status (e.g. birth, adoption, marriage, divorce, loss or gain of spouse's employment), according to the Summary Plan Document.

_____

EMPLOYEE SIGNATURE (Required) DATE

INFORMATION SUPPLIED BY EMPLOYER: Effective date: _____

Frequency of Pay:		☐ Monthly		

[1] This amount is subject to change annualy per IRS guidelines.