EMPLOYEE SPENDING ACCOUNT ENROLLMENT FORM

Academic _____ Classified _____

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

EMPLOYEE NAME LAST	FIRST	MI	☐ M ☐ F SEX	PeopleSoft ID#: SS#:

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: ___/___/___

☐ PLEASE SEND ME A NEW DEBIT CARD

PLEASE COMPLETE

I ELECT THE FOLLOWING:		Monthly Deduction		Annual Election	
				Actual	Maximum
Healthcare Account:	☐ Yes ☐ No	$		$	$ 2,600 Plan Year
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 ___ No ___ Type: ______ Effective Date: ______

Married? Yes ___ No ___ 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:	☐ Semi-Monthly	☐ Monthly	☐ Other	
First Pay Date of Deductions:	/ /		Location/Campus:	