GROUP RESOURCES®

Union Local 1346 and 1815

Cafeteria Plan provided by Warren Consolidated School District

Plan Year 1/1/24 – 12/31/24

Benefits include: Employer Ceded (District) Provided
Employer Ceded Full Time
Employer Ceded Part Time
Employee May Select Optional Employee Contributed FSA

Unreimbursed Medical	**$ 3,050**	**maximum**	**$60.00 per year minimum**
Dependent Day Care	**$ 5,000**	**maximum**	**$60.00 per year minimum**

Use pre-tax dollars to pay for items needed throughout the year

Medical FSA - Elect up to $3,050.00 maximum. Reimburses for deductibles, co-pays, dental, orthodontic, vision, LASIK, weight loss programs (with a note of medical necessity) smoking cessation and some over the counter items for you and your eligible dependents. Reimbursements made by check or direct deposit.

Effective 1-1-20 the Cares Act includes certain OTC medical products as qualified medical expenses. The law allows FSAs to reimburse over-the-counter medicines and drugs without a prescription and permits menstrual care products as a permitted expense.

Dependent FSA- Elect up to $5,000 maximum. Reimburses for day care for children up through age 12 (includes pre-school tuition) for children, latch key, day camps and elder care needed for older adults (IRS allows $5,000 per family per calendar year) Reimbursements made by check or direct deposit.

Enrollment is allowed only once per year. If you miss this opportunity you will need to wait until next year unless there is a qualifying event.

Don't miss out! Sign up for your FSA during open enrollment!
Please submit completed enrollment form to the Employee Benefits Department

DEPENDENT CARE BENEFIT:
IRS extension amendment included allows 2 ½ months grace period for Dependent Care Reimbursement Claims incurred by March 15, 2025 and submitted by March 30, 2025.

MEDICAL FSA BENEFIT:
All expenses must occur on or before 12/31/24.
ALL PAPER CLAIMS MUST BE SUBMITTED TO EBC BY (NOON) 12:00 PM 12/31/24
ALL DEBIT CARD SWIPES / TRANSACTIONS MUST BE DONE BY (NOON) 12:00 PM 12/31/24.

WARREN CONSOLIDATED SCHOOLS
REIMBURSEMENT ACCOUNT ELECTION FORM

Plan Year January 1, 2024-December 31, 2024 **Union Local: 1346/1815**

Employee Name: _____
(Please Print)

Employee Number_____ Social Security Number_____

Date of Birth_____/_____/_____ Gender: Male/Female
Please Circle

Address: _____
(Please Print) Street City State Zip

Email address (required) District or Home_____
Please Circle

Home Phone: (_____) _____ Work Phone: (_____) _____

REIMBURSEMENT ACCOUNTS Effective Date: **January 1, 2024**

A. Employer Ceded $ _____(Full time)

Employer Ceded $ _____(Part time who pay 50% of medical insurance premium)

B. Medical Reimbursement $_____ Annual……. $3.050 Maximum $60 Minimum per year

C. Dependent Care $_____ Annual……. $5,000 Maximum $60 Minimum per year

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I UNDERSTAND THAT I CANNOT CHANGE MY ELECTION AND PAY REDUCTIONS UNLESS I EXPERIENCE A CHANGE IN MY FAMILY STATUS. My employer and I agree that my salary will be reduced by the amount(s) listed above for the benefit option(s) I have elected under the Flexible Spending Plan. I hereby acknowledge that I have read the Understanding of Agreements on the reverse side of this form.

Further, I hereby consent to the use of my personal identifiable information, which I have voluntarily provided on this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, for the sole use of providing benefits, services or any information I have requested.

This agreement is subject to the terms of the Warren Consolidated Schools Flexible Compensation Plan, as amended from time to time, and revokes any prior election and compensation reduction agreement relating to such plan.

_____ Date _____
Employee Signature

_____ Date_____
Employer Signature