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Arlington Central School District
Section 125 Benefit Plan
Enrollment Application

Plan Year: October 1, 2024 - September 30, 2025

- ☐ New Address
- ☐ New Enrollment
- ☐ Current Participant

Name: _____ SS Number: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

Email Address (Required): _____

Medical Insurance Premium Plan:

☐ I elect NOT to participate in the Arlington Central School District's Medical Insurance Premium Plan which entitles me to an allowance of $_____per year. I elect to use my annual allowance for not participating in the medical insurance program as follows (Contact your employer to determine the total allowable amount):

$_____ **Unreimbursed Medical FLEX Account**
$_____ **Dependent Day Care FLEX Account**
$_____ **Cash (subject to Social Security and Income Taxes)**

FLEXible Spending Accounts (Check One):

NOTE: FOR PLAN YEAR 2024 - 2025
ALL ELIGIBLE EMPLOYEES OF ARLINGTON CENTRAL SCHOOL DISTRICT
$150 UMA MIN; $3200 UMA MAX.

☐ I elect the following amounts to be withheld from my paycheck this plan year. I understand that I will NOT pay Federal, State Income, or FICA taxes on the amounts withheld.

For Office Use Only
# of Pay Periods ***Per Pay Period***

$ _____This plan year for the **Unreimbursed Medical FLEX Account**
(minimum $150; maximum $3,200)
Note: No Premiums (eg. COBRA) may be paid through this account.
÷_____= $_____

$_____This plan year for the **Dependent Care FLEX Account**
(up to $5,000; $2,500 if married and filing taxes separately.)
Note: No kindergarten tuition may be paid through this account. ÷_____= $_____

$_____Total withheld this plan year.

☐ I elect **NOT** to participate in the Flexible Spending Accounts for this plan year.

Salary Redirection Agreement:
I have read and understand the explanation I have received regarding my options under the Arlington Central School District FLEXible Benefit Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. I understand that I cannot change any of my elections during the plan year (unless I have a change in status), and that any money left in my account(s) at the end of the plan year will be forfeited.

_____
Employee Signature **Date** **Employer Signature** **Date**

Please Return to Debbie Bungartz by September 20, 2024
Questions call 486-4460 x-20153