H R Support & Consulting Services, Inc.

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BRUNSWICK SCHOOLS – JULY GROUP
Reimbursement Account Benefit Election Form

☐ I elect to participate in my employer's Reimbursement Account(s) program. I agree to contribute the following amount(s) to fund my Account(s):

$ _____ Total annual amount for my Medical Expense Reimbursement Account ($2,500.00 annual maximum).

$ _____ Total annual amount for my Dependent Care Reimbursement Account ($5000. annual maximum; no minimum).

In Addition to my per pay period election for Medical and/or Dependent Care Account I further understand that I will pay the yearly administration fee ($2.10 per pay period): (Check appropriate box)

__ **$54.60 per yr. – 1 account** ___ **$109.20 per yr. – 2 accounts**

I understand that my salary will be reduced by my contribution amount(s), taken from my paycheck in equal amounts each pay period, allowing me to fund my account(s) with pre-tax dollars. I understand that, as my contributions are free of Federal, State and Social Security taxes (if applicable), subsequent Social Security benefits may be slightly reduced.

I understand that:

- this agreement cannot be changed or discontinued during the Plan Year unless my family status or my employment status changes;
- only medical and/or dependent care expenses allowed by the IRS and my employers plan qualify for reimbursement;
- dependent care expenses reimbursed via this plan offset dollar for dollar any child care tax credit;
- funds in my Account(s) must be used before the end of the Plan Year or be forfeited;
- the Plan Year is the period of time beginning **July 1, 2018 and ending on June 30, 2019**; and
- my employer has the **77-day "grace period"** to the Medical Reimbursement Account to submit claims for the 2018-19 PY end should I have a balance remaining in my account on 6/30/2019; and
- **if I have or participate in a Health Savings Account (HSA) I am not eligible to participate in the Medical Reimbursement Account.**

I have received a written description of the Reimbursement Account program. I have read and understand the above agreement.

Employee Signature_____ Date_____

Your name *(please print)* _____

Employer _____ Social Security No. _____/_____/_____

Date of Hire _____/_____/_____ Birth Date _____/_____/_____

Address _____

City _____ State _____ Zip_____

☐ The benefits of the plan have been explained to me and I decline to participate.