Harrison Board of Education
Flexible Spending Account
Compensation Reduction Agreement

for the Plan Year beginning July 1, 2011 and ending June 30, 2012

Employer Use Only
Group No.
Corrected
Change of Status
Effective Date
Termination Date
Division
Date of Hire

Last Name	First Name	M.I.	Identification Number/ SS#
Home Address Street	City	State	Zip Date of Birth / /
E-mail Address			

List Dependents by Last Name, First Name, M.I.	Relationship	Identification/SS#	Date of Birth MM/DD/YY

I hereby make the following election(s) or waiver(s) regarding the benefits made available to me under my employer's Flexible Spending Account and acknowledge my understanding that:

- I elect to reduce my annual, taxable compensation by an amount equal to the total value of the benefits specified below;
- the annual amount will be deducted in approximately equal sums from my regular paychecks during the coming Plan Year;
- this election will remain in effect until the last day of the Plan Year during which I am a participant;
- my election may be changed only upon the occurrence of a Change in Family Status as described in the Plan Document;
- by taking less taxable pay, my Social Security benefits could be reduced;

- this form must be completed and returned to the Harrison Board of Education, 517 Hamilton Street, Harrison, NJ 07029 no later than Friday, June 17, 2011.

Premium Conversion Plan

☑ Medical/ Prescription Drug
Dental/Vision

1.5% of Base Pay
per Pay Period

☐ waive participation

- I have been given the opportunity to participate in the Flexible Spending Account and have indicated my election(s) or waiver(s) above. I acknowledge that I am not eligible to change my participation until the next enrollment period, or if earlier, the occurrence of a Change in Family Status.

Employee Signature _____ Date _____

Daytime Phone Number _____ Evening Phone Number _____