

# St. Cloud Area School District 742

**Enrollment Form**

**10/1/09 – 9/30/10**

### Employer Use Only

Date of Hire	Effective Date	Payroll Effective Date	Location/Department	Annual Salary
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Must Choose One:       9-10 Month Employee                       12 Month Employee & Teachers

### EMPLOYEE INFORMATION

Last Name		First Name		Middle Initial
Home Address		City	State	Zip Code
Home Telephone Number (      )	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		
Social Security Number	Date of Birth	Primary E-mail Address		

If you wish to have your Explanation of Benefits (EOB) sent to your primary e-mail address, please check .     Yes     No  
 Note: If you choose to have it sent electronically, you **will not** receive a hard copy via regular mail.

	<i>Per Pay</i>	<i>Plan Year Amount</i>
<b>Flexible Spending Account</b> <input type="checkbox"/> I choose to participate (Maximum \$10,000 for the plan year) <input type="checkbox"/> I choose not to participate	\$ _____	\$ _____
<b>Dependent Care Account</b> <input type="checkbox"/> I choose to participate (Maximum \$5,000.00 for the plan year/\$416.66 per mo.) <input type="checkbox"/> I choose not to participate	\$ _____	\$ _____
<b>Flexible Spending Account and Dependent Care Account Reimbursement: Direct deposit required (please complete a Credit Authorization Form)</b>		
<b>For Additional Debit Card(s) for a qualifying spouse, call SOMI customer service at (651) 695-2555 or 1-888-330-8408</b>		

### AUTHORIZATION/SALARY REDUCTION AGREEMENT

- I understand that in order to be eligible for the coverages I have elected, I must meet any applicable actively at work requirement as defined by the insurance contracts.
- I hereby elect to participate in ISD 742 St. Cloud Area Schools' (The Company) Flexible Benefit Plan (The Plan) for the Plan Year. I understand the benefits eligible under the Flexible Benefit Plan fall into the following categories: Flexible Spending Account, and Dependent Care Account.
- I understand and agree if my expenses in any of the categories above do not reach the amount I have allocated to the program for reimbursement or payment, I will forfeit any amounts remaining in that program at the end of the Plan Year, and I assume this risk of forfeiture.
- I understand all expenses for which I seek reimbursement must be for eligible services incurred during the Plan Year, while I am a plan participant.
- This plan is regulated by Internal Revenue Code Sections 125 and 129, and is subject to discrimination regulations. In the event that the Plan is found to be out of compliance with discrimination rules, I may be required to reduce or eliminate my pre-tax deduction election.
- I authorize the Company to reduce my regular compensation per pay period for all employee benefits which I have elected and deductions made for the purpose of recovering any ineligible benefit payments. This authorization shall remain in force for this Plan Year and each subsequent Plan Year, or until my participation in the employee benefit plan(s) terminates.
- By providing my e-mail address, I Authorize and Consent to the use of e-mail for communications regarding my employee benefits. I understand that my e-mail address is private and will be used solely for benefit administration purposes.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### SOMI USE ONLY

Rims:	Flex:	Rx:	Notice:	Other:
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