Stafford Board of Education

Section 125 Flexible Spending Plan Highlights and Enrollment Instructions

Start Date:	• July 1, 2022
Plan Year:	• July 1 to June 30
Eligibility:	• Full time and part time hours per week (regularly scheduled) • First of the month following the date of hire.

You do not have to be enrolled in your employer's group health plan to enroll in this Flex Spending plan.

Annual Elections:	• Dependent Care (DCR): $5,000.00 maximum
2 ½ Month Grace Period*: *The 2 ½ Month Grace Period & Year End Run-off Period Run Concurrently	• Eligible DCR expenses can be incurred up to 2 ½ months following the end of the plan year and applied to any remaining account balance in the prior plan year.
Year End 90 Day Run-off Period*:	• Reimbursements can be submitted up to 90 days following the end of the plan year.
Claim Reimbursement:	• Processed weekly ($20.00 minimum reimbursement)
Reimbursement Type(s):	• Check / Direct Deposit
Plan Year Payroll Deductions:	• 20
Date of 1st Deduction:	• September 16, 2022
Your ABS Account Manager is:	• Josh at ext. 427 (josh@abs125.com)

Here's How to Enroll in Your Section 125 Plan
Follow these simple steps:

1. If you meet the eligibility requirements, please complete the Enrollment Form.
2. Estimate your annual reimbursable health-care/dependent-care related expenses using the worksheet on the back of the enrollment form or the FSA calculator on the ABS website.
3. If you use the Dependent Care Auto-Affidavit a new form must be completed for the new Plan Year.

***Send completed enrollment form to Lori Dobson by June 24, 2022.**

Questions? Need Help? First, read the "How to Save on Medical & Child Care Expenses" employee handbook. If you do not have one, contact Human Resources, visit us on the web at www.abs125.com, check out the ABS Mobile App or call 1-877-732-8125 from 8:00am to 5:00pm E.S.T. Monday through Friday.

ABS Advanced Benefit Strategies
Your Flexible Benefits Specialists

Sec. 129 DCR Enrollment IRS Section 129

Dependent Care Reimbursement (DCR) Account

I. Employee Enrollment

Employer Name:					
Your Name (last, first, middle)	Social Security Number		Date of Birth	Gender	Marital Status
Mailing Address	City	State	Zip	( ) Day Time Phone Number	
email address:					

II. List Dependents *(If any)*

Spouse's name (last, first, middle)	Date of Birth	Dependent's name (last, first, middle)	Date of Birth
Dependent's name (last, first, middle)	Date of Birth	Dependent's name (last, first, middle)	Date of Birth

III. Enrollment Election *(check which plans you want and complete information)*

☐ Yes, I elect to participate in a Dependent Care Reimbursement (DCR) Account: Annual Election: $_____

☐ No, I do not elect to participate.

Name of Dependent Care Provider:	Tax ID # or SS #

IV. Certification

I certify that all the information on this form is correct. I understand that: Any amount remaining in my Dependent Care Reimbursement (DCR), accounts at year end will be forfeited in accordance with current plan provisions and the IRS tax laws; and that all plan deductions are in effect for the full plan year and cannot be changed or stopped unless I experience a change in family or employment status.

Employee's Signature: _____ Date: _____

Return completed Enrollment Form to your Benefit Department

Employer Use REQUIRED	Date of Hire: / /	Effective Date: / /	# of Paychecks remaining this Plan Year:
Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly			Pay Date of First Deduction: / /
Dependent Care Deduction Per Pay Period: $			
☐ Mid-Year Status Change (See plan document for list of qualifying events) Explain:			
Note to employer Representative: Please retain the original copy of this form for you records.			

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