San Diego Unified
SCHOOL DISTRICT

FINANCE DIVISION
Employee Benefits Department
P - 619.725.8130
F - 619.725.8132

2024 FLEXIBLE SPENDING ACCOUNT ELECTION FORM

Last Name: **First Name:** **Employee ID#:**

Address: **Phone: (   )**

City: **State:** **Zip:**

Email:

☐ ***HEALTH CARE FSA*** **- $3,050 annual maximum per employee**

I wish to contribute an **annual total** of $____________for the 2024 plan year to my Health Care FSA. Contributions are from monthly earnings with no contribution taken in June or July 2024.

☐ ***DEPENDENT CARE FSA*** **- $5,000 annual maximum per family**

I wish to contribute an **annual total** of $___________ for the 2024 plan year to my Dependent Care FSA. I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, the annual maximum is $2,500. Contributions are from monthly earnings with no contribution taken in June or July 2024.

☐ ***FLEX DEBIT CARD*** **(for Health FSA only) --** I am interested in receiving a Flex Debit Card.

By checking this box, I understand that American Fidelity will send me a Flex Debit Card. Flex debit cards are also available for eligible dependents over the age of 18. To request additional debit cards, please contact American Fidelity directly at flex@americanfidelity.com or call (800) 662-1113.

Authorization—*Please Read Carefully*

I request and authorize the District to reduce the amount of salary payments due me by the above amount(s) and to divert the amount(s) of such reduction(s) to my FSA account(s). I agree that the District shall in no way be liable to me or my successors for any monetary damages which might arise from the federal or state tax consequences of my participation in this plan and consistent therewith. I further agree to save and hold harmless the District from any such monetary damages. I understand that a reimbursable expense cannot be claimed under both an FSA and a Health Reimbursement Account (HRA). The choices I have indicated above must remain in effect for the entire 2024 plan year (01/01/24 to 12/31/24) unless I have an eligible family status change. Eligible family status changes may include: change in employee's legal marital status; number of tax dependents; termination or commencement of employment by employee or dependent; change in work schedule (excluding summer recess and intersession periods); dependent satisfies (or ceases to satisfy) the dependent eligibility requirements.

I understand that any remaining balance in either the Health Care or Dependent Care account at the end of the 2024 plan year will be forfeited.

____ _______________________

Signature of Employee Date

DISTRICT USE ONLY: ***Effective Date:*** ____________ ***PS Entry Date*** _____________

PLEASE RETURN TO:

EMPLOYEE BENEFITS DEPARTMENT
Eugene Brucker Education Center
Room 1150-A

Originals are not needed. Completed form may be sent to: **employeebenefits@sandi.net**