# Boulder Valley School District

## 2009 Flexible Benefits Plan Enrollment (Section 125 Plan)
### (For calendar year January 1, 2009 – December 31, 2009)

_____ _____
Name (please print) School/Worksite

_____
Home Address City State Zip

_____/_____/_____ (___)_____ (___)_____
Social Security Number Day Time Phone Number Evening Phone Number

***Each year, to continue or begin participation in one or more reimbursement accounts, you must enroll by completing the following:***

**PLEASE FILL IN AMOUNTS AS APPLICABLE FOR THE FLEX PLAN(S) YOU WISH TO PARTICIPATE IN:**

**1. Health Care Reimbursement Account:**

**Maximum $3,000/calendar year**

a. Total **annual** (calendar year) deduction $ _____
b. Number of monthly payroll deductions (10 - 12) _____
c. **Monthly** payroll deduction (a divided by b) $_____

**2. Dependent Care (e.g., daycare) Reimbursement Account:**

**Maximum $5,000/family/calendar year**

a. Total **annual** (calendar year) deduction $ _____
b. Number of monthly payroll deductions (10 - 12) _____
c. **Monthly** payroll deduction (a divided by b) $_____

**3. Transportation (mass transit) Reimbursement Account:**

**Maximum $115 per month**

a. Total **annual** (calendar year) deduction $ _____
b. Number of monthly payroll deductions (10 - 12) _____
c. **Monthly** payroll deduction (a divided by b) $_____

***This year, employees who participated in the Health Reimbursement Account in 2007 and/or 2008 can receive the $120 District contribution without making any contribution themselves. This feature is intended for employees who are within four years of retirement. Check the box if you want to receive the $120 district contribution without making a contribution of your own.*** ☐

I have read the information about the flexible benefits plan and wish to participate in at least one of the BVSD Flex Plan reimbursement accounts, as I have indicated above. I understand that election in one or more of these options is irrevocable during the plan year except in case of certain qualifying events (contact Human Resources for details). In addition to reducing my state and federal taxable gross salary and Medicare wages, BVSD Flex will reduce the amount on which eligible PERA benefits are calculated. If I have elected one or more of the reimbursement accounts, I understand that I will forfeit any amounts not claimed for reimbursement and must furnish complete information to the plan administrator. I understand reimbursement may be denied due to Internal Revenue Service restrictions (i.e., non-allowable expenses).

_____ _____
Signature Date

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**Benefits Office use only:**

**Enrollment:** ☐ **New** ☐ **Change** **Effective Date:** _____/_____/_____