DOWNERS GROVE SANITARY DISTRICT
FLEXIBLE COMPENSATION PLAN

AUTHORIZATION FOR BEFORE-TAX CONTRIBUTIONS
TO THE HEALTH CARE REIMBURSEMENT ACCOUNT AND/OR
THE DEPENDENT CARE REIMBURSEMENT ACCOUNT FOR THE
PLAN YEAR OF JUNE 1, 2019 THROUGH MAY 31, 2020

Participant's Name: ______________________________ Social Security Number:_______________
(Please Print)

IMPORTANT NOTICE

This enrollment process is now offered online for employees. Please consider visiting the District's Employee Portal site first before completing this paper form. IF YOU ELECT TO ENROLL WITH A PAPER FORM (IN LIEU OF THE ONLINE OPTION), YOU MUST RETURN THIS AUTHORIZATION TO CLAY CAMPBELL ON OR BEFORE MAY 17, 2019. IF YOU DO NOT RETURN THIS AUTHORIZATION BY THAT DATE, GENERALLY, FOR THE PLAN YEAR OF JUNE 1, 2019 THROUGH MAY 31, 2020, YOU WILL NOT BE ELIGIBLE TO ENROLL IN THE FLEXIBLE SPENDING ACCOUNTS UNDER THE FLEXIBLE COMPENSATION PLAN (THE "PLAN").

Flexible Spending Accounts Enrollment

Check the appropriate item(s):

_____ Enroll me in the Health Care Reimbursement Account

_____ Enroll me in the Dependent Care Reimbursement Account

AUTHORIZATION

I authorize Downers Grove Sanitary District to deduct the following total before-tax amount(s) from my paychecks during the Plan Year of June 1, 2019 through May 31, 2020. The deductions will be made in equal amounts from my paycheck each pay period. These amounts will be deposited into my account(s) maintained by the Downers Grove Sanitary District. My Health Care Reimbursement Account will be used to reimburse me for eligible health care expenses incurred during the Plan Year of June 1, 2019 through May 31, 2020. My Dependent Care Reimbursement Account will be used to reimburse me for eligible dependent care expenses incurred during the Plan Year of June 1, 2019 through May 31, 2020.

	Total Plan Year Amount	Per Pay Period
Health Care Reimbursement Account: (Minimum $130, Maximum $2,700)	$_________	$______
Dependent Care Reimbursement Account: (Minimum $100, Maximum $5,000; $2,500 if married, filing separately)	$_________	$______
Total	$_________	$______

I have read the Summary Plan Description provided to me. I understand that the elections that I have made above will take effect no earlier than June 1, 2019 and will remain in effect from June 1, 2019 through May 31, 2020. The elections cannot be changed by me other than at the beginning of the Plan Year, except under certain circumstances as noted in the Summary Plan Description. I also understand that I cannot transfer money between my health care reimbursement account and my dependent care reimbursement account. Further, I understand that I will forfeit any money in my account(s) that I have not used during the Plan Year of June 1, 2019 through May 31, 2020 or during the grace period for the Plan Year which ends August 14, 2020.

Finally, I understand that because the elections I have made above are before-tax contributions, the amount(s) withheld will reduce my gross wages for purposes of calculation of any benefits for which I may be entitled under Social Security and the Illinois Municipal Retirement Fund.

I hereby agree to have the Downers Grove Sanitary District reduce my before-tax pay in the amount I have designated above.

____ Date:______________________

Participant's Signature

Received by:_________________________________ Date:______________________