

Franklin Central Supervisory Union Flexible Spending Account Plan

Personal Information

We need the following information for all employees participating in either the Health Care Reimbursement and/or Dependent Care Assistance Account. **Due to privacy issues, we will only discuss your account with you. However, you may authorize us to discuss your account(s) with your spouse/dependents by indicating in the box below.**

YOUR NAME:	
MAILING ADDRESS:	
CITY, STATE, ZIP CODE:	PHONE:
E-MAIL:	
MARTIAL STATUS: (PLEASE CIRCLE) SINGLE MARRIED CIVIL UNION* SAME-SEX MARRIED* DOMESTIC PARTNER*	
* Due to Federal Income Tax Regulations, Civil Union, Same-Sex Married and Domestic Partner's expenses are not eligible for reimbursement under a Flexible Spending Account Plan unless the partner is considered a dependent and claimed as such on your federal income tax return.	

LIST ALL ELIGIBLE DEPENDENTS INCLUDING YOUR SPOUSE

FULL NAME <i>(DO NOT INCLUDE YOURSELF)</i>	Date of Birth	M/F	Relationship To You
JOHN/JANE DOE	00/00/00	M/F	SPOUSE

THOSE NAMED ABOVE, **ARE** ____, **ARE NOT** ____ (CHECK ONE) AUTHORIZED TO DISCUSS THE STATUS OF MY REIMBURSEMENT ACCOUNTS, INCLUDING PAYMENTS OF BENEFITS WITH FUTURE PLANNING ASSOCIATES, INC.

SIGNATURE:	DATE:
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PLEASE RETURN THIS FORM WITH YOUR ELECTION OF BENEFITS FORM