2019 OAHS FLEX PLAN ENROLLMENT

EMPLOYER: **Ortonville Area Health Services**

EMPLOYEE'S FULL NAME: _____

EMPLOYEE'S DAYTIME PHONE # _____

Using 24 pay periods per year, I request the following amounts to be deducted **PER PAY PERIOD** on a pre-tax basis:

Medical Expenses: _____ / pay period (using 24 pay periods a year)
($2650 per employee limit)**

Dependent Care: _____ / pay period (using 24 pay periods a year)
(max $5000 per family unit) **

NOTE: OAHS health and dental premiums will be deducted pre-taxed if enrolled
AFLAC: see their enrollment form

***AUTHORIZATION**: I certify the above information to be correct and true to the best of my knowledge and that the children whom I will be claiming dependent expenses or child care, either reside with me or are legally dependent on me for their support. I understand that the Flexible Compensation deduction(s) will be in effect for the plan year and cannot be changed unless I experience a change (qualifying event) in my family status.*

Signature _____ ***Date*** _____

PRE-ENROLLMENT WORKSHEET

Premium Expenses *(all premium costs per year)* _____ *(1)*

Medical Expense _____ *(2)*
(amounts usually paid toward deductibles and co-insurance portion of premiums, orthodontics, eye care, prescriptions and other miscellaneous health care in a year.)

Dependent Care _____ (3)
(amount paid for day care expenses in a year - $5000 per family limit)

Total Amount per year (add lines 1+2+3) _____ (4)

Estimated TOTAL NET SAVINGS (line 4 x 0.25) _____

***The total tax savings represents the Federal, State and FICA taxes.*
Actual savings may differ. This also assumes no deduction realized on Form 1040