Flexible Spending Accounts Election Form

Make your Flexible Spending Account elections below by checking the appropriate benefit and entering your election amount. Sign and return the form to Human Resources.

Employee Name

Employee Social Security Number

- -

I choose the following coverage type and premium deduction:

		Contribution Per Pay Period	X	Number of Pay Periods in Plan Year	=	Your Annual Election Amount
Dependent Care FSA (not to exceed $5,000)	☐	$ _____	X	24	=	$ _____
Health Care FSA (not to exceed $2,700)	☐	$ _____	X	24	=	$ _____

Please select your enrollment option below, then sign and date your form and submit it to your benefits services department:

☐ I elect to participate in the Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security Benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's plan.

If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

☐ Waive: I decline enrollment in the Flexible Spending Account Plan.

I understand this election coverage is effective January 1, 2020, through December 31, 2020.

Employee Signature	Date