

FLEXIBLE SPENDING ACCOUNT

Account number

P84758

Employee Information

Your name (last, first, middle initial)

Social security number/ID number

Address (street)

City

State

ZIP code

Date of birth (mo/day/yr)

Your email address

male

female

Spouse's name

Spouse's ID/SSN.

Spouse's date of birth (mo/day/yr)

I want to participate in our Flexible Spending Account (FSA).

Reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to our FSA. I understand this reduces my wages for Social Security purposes, and may reduce my Social Security disability and retirement benefits. I understand I will not earn interest on my contribution. I also understand that once I have made this election, I can only change it during the election period prior to the next plan year, or if there has been a qualifying change in my family's status or employment as determined by IRS regulations. I further understand that any contributions in the FSA not used for my eligible expenses at the time I terminate participation, or at the end of any plan year, will be forfeited. Because Section 125(b) of the Internal Revenue Code establishes limits on participation in FSA by highly compensated employees and key employees which cannot be determined until the participation of all employees in both contributions and benefits has been tested under the applicable rules, it may be required by law that a portion of your salary reduction contributions to this FSA be returned to you regardless of the terms of your election to participate. Any amount so returned will be a part of your taxable income. I certify that I have not been and will not be reimbursed for these expenses from this or any other benefit plan and have/will not include them as itemized deductions or as a tax credit on my personal income tax returns.

NOTE: Changes in election allowed due to a qualifying change in family status must be made no later than 30 days after the date of the qualifying change in status.

Pay period: (Check the box which indicates the frequency of your paychecks)

weekly

bi-weekly

monthly

twice-monthly

other

	Health Care	Dependent Care	- Note: Dependent care spending accounts are not medical spending accounts for a participant's spouse or children. It's day care (baby-sitting) for children or elderly dependents.
*Total annual election	\$ _____	\$ _____	

*The annual election should be based on the number of pay periods remaining.

I decline to participate in our FSA.

I realize that if my election form is not received by the end of the election period, I have declined to participate by default. I understand that I will not be eligible to participate again until the following plan year unless there has been a qualifying change in my family's status or employment.

*

Signature

Date signed

*Date signed **must** be prior to effective date of the plan year. If change of status occurs during plan year, date signed **must** be prior to pay period in which the above listed contributions will go into effect.

Employer to Complete this Section

Company name as it appears on your billing

Location/unit

Drake University

Beginning pay period date (refer to quick reference guide)

Reason for change

initial request

change