

Administered by:  
Nyhart

# UNIVERSITY OF SOUTHERN INDIANA

Plan Year \_\_\_\_\_

**Employee Information** (Please Print)

**Section 125 Plan Enrollment Form**

Name (Last, First, MI) \_\_\_\_\_ Employee's E-Mail Address: \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  Male  Female

I Decline Flexible Spending Account Coverage (If you are declining coverage, skip to pretax premium authorization.)

<b>Benefit Election</b>	<b>Annual Amount</b>	<b># Pay Periods</b>	<b>Payroll Deductions</b>
Health Care Spending Account	\$ _____	÷ _____	= \$ _____
Dependent Care Spending Account	\$ _____	÷ _____	= \$ _____
<b>Total Salary Reduction Per Pay Period</b>			<b>= \$ _____</b>

**I understand and agree that:**

- ✓ My election under this form cannot be revoked or changed before the first day of the next plan year unless there is a change in my family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of child, or change in employment status) as authorized by the Internal Revenue Code or regulations thereunder and that my change in election must be consistent with my change in family status.
- ✓ Any election to receive health care reimbursement and/or dependent care reimbursement will be subject to the additional rules set out in the plan document.
- ✓ I must disclose the name and tax identification number of my dependent care provider(s) on my federal income tax form if I participate in the Dependent Care Spending Account.
- ✓ Contributions may not be transferred between spending accounts and any amounts remaining at year-end will be forfeited.

**Mandatory Authorization for Direct Deposit**

I hereby authorize Nyhart to initiate deposit entries, and any adjustments to correct errors, to my

- saving account
- checking account

indicated below and the bank / credit union named below to debit same to such account.

Bank/Credit Union \_\_\_\_\_ Account Number \_\_\_\_\_

**Pre Tax Premium Authorization**

I authorize my share of premiums for eligible employee benefit plans to be deducted from my wages on a pre-tax basis. I understand that my election to participate in the plan(s) and payroll deductions are binding for the plan year, unless I have a qualifying change in status.

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY EMPLOYER**

Employer's Signature \_\_\_\_\_ Date Approved \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Frequency \_\_\_\_\_ 1st Payroll Deduction \_\_\_\_/\_\_\_\_/\_\_\_\_