

Flexible Benefit Plan Election Salary Reduction Form

Administered by:
Nyhart

University of Southern Indiana

Plan Year: 2019

Employee Information (please print or type)

Name (Last, First, MI) _____

Employee ID Number _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Email _____

I Elect to participate in the Flexible Spending Account for the Plan Year. I understand that my share of the premiums for the eligible plan(s) in which I have elected to participate will be deducted from my salary on a pre-tax basis unless I elect otherwise on a separate form.

I Decline to participate in the Flexible Spending Account for the Plan Year. *(If you are declining coverage, omit the rest of this form and sign where indicated.)*

	Annual Election		# Pay Periods		Reduction/Pay
General Purpose Flexible Spending Account Maximum Election \$2,700.00	\$ _____	÷	_____	=	\$ _____
Dependent Care Flexible Spending Account Maximum Election \$5,000.00/ household	\$ _____	÷	_____	=	\$ _____
Total Salary Reduction / Pay				=	\$ _____

I understand and agree that:

- ✓ I cannot change or revoke any of my election(s) at any time during the plan year unless I have a change in status and my election is consistent with such change.
- ✓ Any amounts of my election(s) that are not used by the end of Plan Year will be forfeited.
- ✓ Claims must be submitted within 90 days of the end of the Plan Year.
- ✓ I agree to provide the plan administrator with substantiating documentation when I seek reimbursement or when supporting documentation is requested.
- ✓ I cannot seek reimbursement from the FSA for an expense which I intend on taking as a deduction or credit on my tax return.
- ✓ I must disclose the name and Tax ID Number of my dependent care provider(s) on my federal income tax form if I participate in the Dependent Care FSA.
- ✓ 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 would like to receive my FSA debit card requests for substantiation through email.

Request for Direct Deposit

I hereby authorize Nyhart to initiate deposit entries, and any adjustments to correct errors, to my **checking account** / **savings account** indicated below. In order to complete the request for direct deposit, please attach a void check. Failure to provide this may result in processing delays.

Bank/Credit Union Routing Number: _____ **Account Number:** _____

Employee Signature: _____ **Date:** _____

TO BE COMPLETED BY EMPLOYER

Employer's Signature _____ **Date Approved:** ____/____/____

Participant's Effective Date: ____/____/____ **Date of 1st Payroll Deduction:** ____/____/____