

**Flexible Spending Account Enrollment**  
and Compensation Reduction Agreement

<b>HR USE ONLY</b>	
Pay Period _____	_____
Beginning Date _____	_____
Group _____	_____

Employer Andrews University

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex: \_\_\_\_\_ Female \_\_\_\_\_ Male Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married

**REASON FOR SUBMITTING FORM:**

**If you have any questions please contact the Benefits Office @ 3886.**

\_\_\_\_\_ New Enrollment Effective Date: 7/1/2005 – 6/30/2006 (No change will be effective until approved by the Plan.)

\_\_\_\_\_ Change in Family Status Specific reason for change: \_\_\_\_\_

**REIMBURSEMENT ACCOUNT – The following elections must be made annually for each benefit year.**

*Health Care Reimbursement*

\_\_\_\_\_ I elect to allocate \$ \_\_\_\_\_ (before tax) per plan year for funding reimbursement of qualified health care expenses NOT covered under my health care plan (up to \$3,000 per plan year)

\_\_\_\_\_ YES \_\_\_\_\_ NO I wish to have my deductible, co-pays, and/or out-of-pocket expenses automatically reimbursed from the Flexible Spending Account. (Only available with IBA medical coverage and no coordination of benefits.)

\_\_\_\_\_ I do NOT wish to set aside money in the account for the reimbursement of health care expenses.

*Dependent Care Reimbursement*

\_\_\_\_\_ I elect to allocate \$ \_\_\_\_\_ (before tax) per plan year for funding for reimbursement of qualified dependent care expenses (up to \$5,000 per plan year)

\_\_\_\_\_ I do NOT wish to set aside money for the reimbursement of dependent care expenses.

**AUTHORIZATION AND SIGNATURE:** I understand my enrollment in the Andrews University's Flexible Spending Account plan is voluntary. In accordance with my rights under the Plan I elect the benefits indicated above, and I agree that my cash compensation will be reduced by the amounts indicated for each pay period. I understand that I cannot change or revoke any of my election(s) (including an election not to participate) for the plan year. I can change my election for dependent care reimbursement in the event I have a change in family status, as approved by the Plan. Health Care Reimbursement can only be elected or changed at the time of open enrollment. I understand that this agreement or any portion of this agreement will automatically terminate if the Plan is terminated or discontinued. I understand that I cannot seek reimbursement from the account for a qualified medical or dependent care expense that I intend on taking as a deduction or credit on my tax return. I also understand and agree that I forfeit any unused amounts at the end of the plan year.

This Agreement is subject to the terms of the Andrews University's Flexible Spending Account plan, as amended from time to time in effect, and revokes any prior enrollment and compensation reduction agreement relating to such plan.

Signature \_\_\_\_\_ Date \_\_\_\_\_