FLEXIBLE SPENDING ACCOUNT ENROLLMENT / WAIVER FORM

October 1, 2019 – September 30, 2020 Plan Year

Please Check Appropriate Box: ❑ Monthly Payroll ❑ Bi-Weekly Payroll		
Last Name: First Name:	Date of Birth:	Bradley University Health Plan: ❑ Yes ❑ No Other group health insurance: ❑ Yes ❑ No
Address:	City:	State: Zip: **Effective Date:**
❑ Single ❑ Married ❑ Male ❑ Female	E-Mail:	Social Security Number: Phone Number:
Spouse Name:	Date of Birth:	Other group health insurance: ❑ Yes ❑ No
Eligible dependents are those you can claim on your income tax return.		
Dependent Name:	Relationship:	Date of Birth: School or other group health insurance: ❑ Yes ❑ No
Dependent Name:	Relationship:	Date of Birth: School or other group health insurance: ❑ Yes ❑ No
Dependent Name:	Relationship:	Date of Birth: School or other group health insurance: ❑ Yes ❑ No

Lines A and/or B or C must be completed every year even if I wish for my deductions to the unreimbursed medical plan or dependent care plan to remain the same as the previous year.

A. I wish to elect $_____ **PER PAY PERIOD*** totaling $ _____ **FOR THE PLAN YEAR** to be withheld on a pre-tax basis for **out-of-pocket health related expenses.** ($2,700 Annual Max). I choose the following option for the 2019-2020 plan year, which I understand cannot be changed until the next open enrollment period (Choose only 1 of the 3 options).

❑ I hereby elect to participate in the **Flexible Spending Debit Card** program. I understand that, while most claims will auto-substantiate at the time of purchase. I may be required to submit some claims directly to Benefit Planning Consultants for processing.

❑ I hereby elect to participate in the **Flexible Spending Auto-Reimbursement** program under my Section 125 Flexible Spending Account. (Auto-Reimbursement pertains only to those participating in the University's health plan.) I understand that I may not elect Auto-Reimbursement if I, or any of my dependents have any other coverage in addition to the University's coverage, as the Internal Revenue Service requires that a flexible spending account be the last possible payer on the expense. I understand that I do not qualify for Auto-Reimbursement if any one of my dependents does not qualify as a dependent based on the Internal Revenue Code even if that person is eligible and covered under my group health plan.

❑ I **do NOT** wish to participate in the **Flexible Spending Debit Card program** or **Flexible Spending Auto-Reimbursement** program.
I understand that I must submit all claims directly to Benefit Planning Consultants for processing.

B. I wish to elect $_____ **PER PAY PERIOD*** totaling $ _____ **FOR THE PLAN YEAR** to be withheld on a pre-tax basis for **employment-related dependent care expenses.** ($5,000 Annual Maximum, if married filing jointly; $2,500 filing a separate return)

Electronic Deposit of reimbursements is available. Complete enclosed "Authorization Agreement for Authorized Direct Deposit" form.

DO NOT overestimate A and/or B contribution(s) as changes CANNOT be made during the plan year (unless you have a qualifying event as allowed by the plan), nor will remaining money be reimbursed at end of the plan year.

C. _____ **WAIVER of Both Out-of-Pocket Health Care and Dependent Care Participation**: After consideration, I choose not to participate in the Out-of-Pocket Health Care and Dependent Care flexible benefit plan for the 2019-2020 plan year.

I hereby certify the above information to be true and correct. I understand that this agreement is subject to the terms and conditions of the employer's plan, as amended from time to time and that this plan shall be governed by and construed in accordance with applicable laws. I understand that this document revokes any and all prior elections for participation in the flexible spending plan. I further understand that all expenses I submit for reimbursement are not eligible for payment or reimbursement from any other source, such as an insurance coverage I, or my dependents, may have.

Date_____ ***Employee Signature***_____

***PER PAY PERIOD = 12 PAY PERIODS FOR MONTHLY AND 24 PAY PERIODS FOR BI-WEEKLY FOR THE PLAN YEAR**