# University of Dayton
# Medical Flexible Spending Account
# Dependent Care Flexible Spending Account
# Enrollment Form

myCAFETERIAPLAN.com
FLEXIBLE SPENDING ACCOUNTS

| EMPLOYEE INFORMATION: *(Completed by Employee)* | |
|---|---|
| Name: | |
| Email: | |
| SSN (last 4 digits): | |
| Address: | |
| City: | Date of Hire: |
| State: | Zip Code: |
| Daytime Phone: ( ) | Date of Birth: |

**I authorize my employer to make the following salary reductions:** *Indicate below the options in which you would like to participate.*

☐ **Medical Flexible Spending Account:***

*Please visit **www.mycafeteriaplan.com** for a list of eligible expenses

**** Please note: If you or your spouse have enrolled in an Health Savings Account (HSA) benefit, you are only eligible for the Limited Medical Flexible Spending Account (FSA). Please see below.***

| | | |
|---|---|---|
| A. Total Per Pay contribution: | **A.** | $ |
| B. Total number of pay periods in plan year: | **B.** | |
| C. Total Annual Election: *Line A multiplied by line B* ***(Maximum allowed per family: $2,500 )*** | **C.** | $ |

OR

☐ **Limited Medical Flexible Spending Account:**

*Eligible expenses include Eye Exams, Glasses, and non-cosmetic dental procedures only*

| | | |
|---|---|---|
| D. Total Per Pay contribution: | **D.** | $ |
| E. Total number of pay periods in plan year: | **E.** | |
| F. Total Annual Election: *Line D multiplied by line E* ***(Maximum allowed per family: $2,500 )*** | **F.** | $ |

☐ **Dependent FSA Account:** *Eligible daycare expenses for*

1. *If married, your spouse must also be employed*
2. *Age limit for dependent children: up to the 13th birthday*
3. *May be used for elderly care if they meet the dependent requirement as defined by the IRS*
4. *Maximum Allowed: $5,000 if single or married filing jointly, $2500 if married filing separately*
5. *Dependent must reside in your household the majority of the year*
6. *Tuition expenses for K-12 school **are not eligible***

| | | |
|---|---|---|
| G. Total Per Pay contribution: | **G.** | $ |
| H. Total number of pay periods in plan year: | **H.** | |
| I. Total Annual Election: *Line G multiplied by line H* ***(Maximum allowed: See #4 above)*** | **I.** | $ |

## I understand that:

* I cannot change this election during the plan year unless I have a change in status as defined by the Internal Revenue Code and Regulations.
* Any amount remaining in my reimbursement accounts at the end of the plan year will be forfeited.
* My Social Security benefits may be slightly reduced by this election.
* This election replaces any previous elections and will terminate on the earlier of:
  - (1) the end of the plan year.
  - (2) when I am no longer being paid compensation in an amount at least equal to my total salary reduction.
  - (3) termination of the plan.
  - (4) termination of employment unless continued under COBRA.
* My Employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

Signature: _____ Date: _____



Please return your completed form to the University of Dayton Human Resource Department + 1614