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: $5,000)***	**C.**	$ 0.00

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: $5,000)***	**F.**	$ 0.00

☐ **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.**	$ 0.00

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