The University of Vermont Calendar Year 2020 Flexible Spending Account Enrollment Form

Complete / Print / Sign / Send to Human Resources Services via uvm.edu/filetransfer to HRSinfo@uvm.edu

EMPLOYEE INFORMATION:

(Last) (First) (M.I.) NAME:	EMPLOYEE ID #:
ADDRESS: CITY, STATE ZIP:	CONTACT PHONE:

SPOUSE AND DEPENDENT INFORMATION: (Individuals must meet the **IRS definition** of a dependent. Use an additional sheet of paper, if needed.)

NAME (Last, First, MI):	RELATION:	DOB:

PLAN INFORMATION: (Read the notes below and then please check one box for each of the following questions.) The healthcare and/or dependent care expenses of a spouse and dependent children are reimbursable.

Flexible Spending Account Election. Note to employees joining during the calendar year: You may enroll only from the date of hire until the end of the year, and must consider amounts set aside at your previous employer toward your total allowed withholding for the year.

During a Leave of Absence: Your **dependent care** expense account will end, regardless of whether your leave is paid or unpaid. Your **health care** expense account will end if your leave is unpaid. You must re-enroll upon your return. HRSInfo@uvm.edu for details.

Planning to Retire in the Year Ahead? If so, please provide your: **Proposed Retirement Date**:
Your deduction will be evenly spread out over the number of payrolls between January 1 and your proposed retirement date. (Note that federal law requires you to SPEND your entire FSA pledge ***before* your retirement date**. e-Mail HRSinfo@uvm.edu with questions.)

Health Care Expense Reimbursement Account Election for you and your family

☐ I DO wish to participate in the Health Care Plan (**$2,700**). **Annual (CY)** amount of Salary Reduction: HEALTH CARE $

Child Care/Dependent Care Expense Reimbursement Account Election (if applicable)

☐ I DO wish to participate in the Dependent Care Plan (**$5,000 family max**). **Annual (CY)** amount of Salary Reduction: DEPENDENT CARE $

I certify that I wish to participate in the Plan and elect to have the total amount stated above deducted from my paychecks. I understand that this will lower my gross pay and, consequently, my tax base and my Social Security base.

I must continue enrollment in the Plan, with my above-stated Salary Reduction Amount, until the end of the Plan Year or my employment termination date, whichever occurs first. However, in the event of a change in my family status (i.e. marriage, divorce, birth, etc.) I may change or revoke my Salary Reduction Amount. Should my required contributions for the elected benefits be increased or decreased while this agreement remains in effect, my compensation will automatically be adjusted to reflect this change.

At the end of the Plan Year, should my annual Salary Reduction Amount, **for Dependent Care**, exceed my actual annual expenses, the excess will be forfeited. At the end of the Plan Year, should my annual Salary Reduction Amount, **for HealthCare**, exceed my actual annual expenses, I may roll over up to $500 of unclaimed funds in a Flexible Spending Account for healthcare into a new account for the next calendar year. Any amount over $500 will be forfeited.

Section 105 and 125 deductions are pre-tax and may not be itemized when filing IRS Form 1040. Should the Company incur a liability for a failure to withhold Federal, State, Local or FICA taxes due to a fraudulent act of the employee, the employee shall indemnify the Company that liability demand.

EMPLOYEE SIGNATURE: **DATE:**

For Human Resources to Complete:

# of Annual Pay Periods: _____

Amount Deducted per Pay Period: Health Care: _____ Dependent Care: _____ Effective Date: _____

CBA ebpa

Form updated October 2019