UVM Dependent Care and Health Care Flexible Spending Account
2022 ELECTION CHANGE FORM

Questions? Contact Human Resource Services at HRSinfo@uvm.edu or 802-656-3150

COMPLETE, SIGN and SUBMIT FORM TO HRSinfo@uvm.edu via secure file transfer

Employee Information:

Last Name:___________________________First Name:___________________________Employee ID: ________________

Effective Date:________________________

HEALTH CARE I wish to:

- ☐ **CHANGE** my current enrollment from $_____________annually to $______________annually (Max: $2,850) **NOTE: The new total annual amount indicated cannot be "0". The minimum amount "decreased to" cannot be less than the total payroll contributions or FSA-health utilized/reimbursed through the effective date. If you wish to stop your contributions, you must indicate the total payroll contributions or FSA-health utilized/reimbursed through the effective date of the change.**

- ☐ **I DO NOT HAVE** a Current Annual Enrollment and wish to **NEWLY ENROLL** with an annual enrollment of $________________________. This amount will be evenly divided in payroll contributions taken during the remainder of payrolls in this calendar year

DEPENDENT CARE I wish to:

- ☐ **CHANGE** my current enrollment from $_____________annually to $______________annually (Max: $5,000 per family) **NOTE: The new total annual amount indicated cannot be "0". The minimum amount "decreased to" cannot be less than the total payroll contributions made through the effective date. If you wish to stop your contributions, you must indicate the total payroll contributions made through effective date of the change.**

- ☐ **I DO NOT HAVE** a Current Annual Enrollment and wish to **NEWLY ENROLL** with an annual enrollment of $________________________. This amount will be evenly divided in payroll contributions taken during the remainder of payrolls in this calendar year

Employee Certification:

I certify that I wish to participate in the UVM FSA 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 special enrollment period or a change in my family status (i.e., marriage, divorce, birth, etc.), I may change or discontinue further salary reductions. 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 2022 Plan Year, any unspent balances for health care or dependent care will be permitted to rollover into the next year

____   ________________________

Employee Signature   Date