The University of Vermont

Do not use this form for Open Enrollment. Open Enrollment elections must be submitted via PeopleSoft Self-Service.

UVM Dependent Care and Health Care Flexible Spending Account
2023 ELECTION CHANGE FORM

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:

☐ **NEW ENROLLMENT: 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

☐ **CHANGE** my current enrollment from $_____annually to $_____annually (Max: $3,050) **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.**

DEPENDENT CARE I wish to:

☐ **NEW ENROLLMENT: 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

☐ **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.**

Please note: Eligible dependents for dependent care flexible spending are under 13 years or physically/mentally incapable for caring for themselves.

Employee Certification:

I certify that I wish to participate in the UVM FSA Plan. I authorize the pre-tax salary deductions for this benefit to be withheld from my paycheck. 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 pre-tax payroll deductions be adjusted to reflect this change. At the end of the 2023 Plan Year, unspent health care flex balances up to $610 will be rolled over into the following plan year.

_____ _____

Employee Signature Date