University of Louisville
2017 FSA Enrollment Form

You will be making elections for the **January 1, 2017** through **December 31, 2017 Plan Year**. After completing the form, **please sign and return it the Human Resources Department**.

Participant Information – *PLEASE PRINT LEGIBLY*		
First Name		Home Phone ( ) -
Last Name		Work Phone ( ) -
SSN	Employee ID	
Pay Frequency (Select One) ☐ Monthly ☐ BI-Weekly		

PLAN ELECTION DESCRIPTIONS

WAIVER OF MEDICAL COVERAGE CREDIT

If you waive medical coverage, you are eligible to receive an FSA contribution of $175/month in the form of a Waiver Credit from the University. This contribution will automatically go to the Health Care Spending Account unless you elect to have all or part of it deposited into the Dependent Care Spending Account.

☐ **Yes** I am waiving medical coverage and I want all my $175/month to go to a ***Health*** Care Spending account.

OR

☐ **Yes** I am waiving medical coverage and I want all my $175/month to go to ***Dependent*** Care Spending Account.

OR

☐ **NO** I am not waiving medical coverage. I want an FSA in addition to my medical plan. See the section(s) below.

If you are waiving medical coverage, and you want all or part of the dollars to be placed in a Dependent Care Spending Account, receive the Waiver Credit. Please check "Yes" in this section and distribute your Waiver Credit in the FSA section below. If you are not eligible for the Waiver Credit, check no. You will not have any money to spend in the FSA section below.

FLEXIBLE SPENDING ACCOUNT (FSA) CONTRIBUTIONS FROM YOUR PAY

Enter the amount you wish to contribute to each account on an annual basis. Contributions will be withheld from your regular paychecks in equal installments throughout the year on a pre-tax basis. If not contributing, enter "0."

HEALTH CARE SPENDING ACCOUNT
for medical expenses
This is for out-of-pocket medical, dental and vision expenses. You may elect up to a total of $2,550 for the plan year ($150 minimum). If you wish to participate in this account, please enter the amount you wish to elect.

Employee Total Annual Contribution

$_____
Not to exceed $2,550

DEPENDENT CARE SPENDING ACCOUNT
for daycare expenses
This is for day care for your dependents under age 13 and living in your household more than 50% of the year. You may elect up to $5,000 for the plan year ($150 minimum). If you wish to participate in this account, please enter the amount you wish to elect.

Employee Total Annual Contribution

$_____
Not to exceed $5,000

EMPLOYEE AUTHORIZATION

I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan. I have received and read all the authorizations & acknowledgements provided by Chard Snyder for each plan elected. I also acknowledge the receipt of the HIPAA Privacy Notice provided at open enrollment and/or provided on the Chard Snyder website (www.chard-snyder.com).

Signature Date / /

CLIENT USE ONLY (MUST BE COMPLETED BY HR FOR NEW HIRES)

Employee Effective Date / / 1st Contribution Date / / Initials

EMPLOYEE ACKNOWLEDGEMENT & AUTHORIZATIONS (SEE BELOW)

All sections may not apply. Each section is only applicable if you are electing to participate.

FLEXIBLE SPENDING ACCOUNT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year (as shown above) and submit my claims by the end of the run out period or the funds will be forfeited. If my plan provides a carryover, funds remaining in my FSA reimbursement account will be carried over into the new plan year up to my plan's allowed carryover maximum. Funds remaining above my plan's allowed carryover maximum will be forfeited.
- I cannot change my election once the Plan Year begins; my election(s) must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or in employment status.
- My out-of-pocket expenses must be incurred while I am an eligible participant and during the Plan Year to be considered for reimbursement (the date of service, not the date of invoice, must occur during the Plan Year).
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled (premiums, health and/or daycare).
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.

I hereby authorize my employer to deduct from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan.

PLEASE NOTE: DEPENDENT CARE SPENDING ACCOUNT

Participant elections for the Dependent Care FSA are also limited by the following IRS requirements:

- If married and filing an income tax return jointly, the election must be the lesser of $5,000, the participant's earned income, OR the spouse's earned income for the plan year.
- If married and filing an income tax return separately, the election must be the lesser of $2,500 the participant's earned income, OR the spouse's earned income for the plan year.
- If the participant's spouse is not employed and is disabled, an income equivalent of $200 per month for one dependent or $400 per month for more than one dependent may be used.
- If filing an income tax return as a single parent, the election must be the lesser of $5,000 OR the participant's earned income.

BENNY™ PRE-PAID BENEFITS CARD – ACKNOWLEDGEMENT & AUTHORIZATION:

I understand that:

- I have received, reviewed and understand the procedures of this debit card.
- Benefit card funds are authorized only for the payment of qualified expenses as outlined in my employer's plan document.
- The benefit card may be used only for eligible expenses at the point-of-service, and I may be required to submit a claim form with receipts and/or bills to Chard Snyder to substantiate the expense.
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled.
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.
- If I use my benefit card for ineligible expenses, I will be required to pay back the amount that was not covered by my plan.
- If I do not repay amounts used for ineligible FSA expenses, my employer and/or Chard Snyder has the right to cancel my benefit card and deduct this amount from my salary.
- These FSA funds have not or will not be reimbursed under any other plan coverage.
- Chard Snyder will not be held responsible for processing duplicate claims that I have submitted in error.
- The benefit card may not be accepted at all merchants that accept MasterCard/Visa.
- I must check with my employer to verify the monthly fee, if any, to add to the benefit card.

I understand and agree to the terms and conditions specified on this form and authorize Chard Snyder to complete my request as indicated.

DIRECT DEPOSIT – ACKNOWLEDGEMENT & AUTHORIZATION:

I understand that:

- My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
- I permit Chard Snyder to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and/or debit the same to such account.
- I will not hold Chard Snyder responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me, my employer or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.
- Chard Snyder reserves the right to collect a $25 processing fee for transaction returns and reserves the right to periodically change this fee. Chard Snyder is not responsible for any fees that may be incurred and charged to me by my financial institution.
- Direct deposit of my reimbursements shall commence within 4 (four) weeks of receipt of this form.
- My direct deposit may be terminated by any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, cancellation of direct deposit by my employer or in the event that processing fees are incurred and are unpaid for a period of 60 days.

I hereby agree to and understand the information on this form and authorize Chard Snyder to complete my request.