PREMIUM ONLY PLAN AND FLEXIBLE SPENDING ACCOUNTS

Employee Information:

Your name (last, first, middle initial)			IWU ID # 9 _ _ _ _ _ _ _ _
Address (street)	City	State	Zip
Date of birth (mo/day/yr)	Email Address		

SECTION 1: Insurance Premium

I do not have insurance through Illinois Wesleyan University.

☐ I have waived my option to have insurance through Illinois Wesleyan University. I understand that I will not be eligible to change my election until the following plan year, unless there has been a qualifying change in my family's status, employment or group health care coverage.

I have insurance through Illinois Wesleyan University.

☐ Reduce my salary by the amount I pay for the group benefits my employer allows. I understand this may reduce my potential Social Security benefits. I realize I can change this election only during the election period prior to any plan year or if there has been a qualifying change in my family's status, employment or group health care coverage.

SECTION 2: Flexible Spending Accounts

I do not want to participate in our Flexible Spending Account (FSA).

☐ I have waived my option to participate in the Flexible Spending Accounts for health care and dependent care reimbursements. I understand that I will not be eligible to change my election until the following plan year, unless there has been a qualifying change in my family's status, employment or group health care coverage.

I want to participate in our Flexible Spending Account (FSA).

☐ Reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to our FSA. I understand this reduces my wages for Social Security purposes, and may reduce my Social Security disability and retirement benefits. I understand I will not earn interest on my contribution. I also understand that once I have made this election, I can only change it during the election period prior to the next plan year, or if there has been a qualifying change in my family status or employment as determined by IRS regulations. I further understand that any contributions in the FSA not used for my eligible expenses at the time I terminate participation, or at the end of any plan year, will be forfeited.

Note: Changes in election allowed due to a qualifying change in the family status must be made no later than 31 days after the date of the qualifying change in the status.

Pay period: (Check the box which indicates the frequency of your paychecks) ☐ bi-weekly (26 pays) ☐ monthly (12 pays)

	Health Care	Dependent Care	Note: Dependent Care Spending accounts are not medical spending accounts for a participant's spouse or children. Dependent care is day care (babysitting) for children or elderly dependents.
Election per Pay Period			
*** Total Annual Election**			

* The annual election should be based on the number of pay periods in the calendar year for which you are making this election.

Terms and Conditions: PLEASE READ CAREFULLY*:*

- If I should terminate employment I will be eligible to submit claims for health and child/dependent care reimbursement until the earlier of 1) the date the Flexible Spending Account balance is $0, or 2) the last day of the claim filing period. Health claims must be incurred prior to date of termination.
- I certify that all expenses for which I will request reimbursement for under these reimbursement accounts are valid expenses under the Plan and the Internal Revenue Code. I also certify that they are not reimbursable under another plan or source and may not be claimed on any federal income tax deduction or credit. If I have inadvertently received payment for an ineligible expense, I agree to provide repayment to the plan.

_____ _____

Signature **Date Signed** (must be prior to pay period in which the above listed contributions will go into effect)

Return your completed form to Human Resources, Holmes Hall 209.