



UNIVERSITY OF DETROIT MERCY
FLEXIBLE SPENDING ACCOUNT ELECTION FORM

Plan Year January 1, 2012 - December 31, 2012

Employee Name: _____ Social Security No.: _____
(Please Print)

Employee T#: _____ Date of Birth: ____/____/____ Gender: Male/Female
Please Circle

Address: _____
Street City State Zip

Email address (required): Work or Home _____
Please Circle

Home Phone: (____) _____ Work Phone: (____) _____

The debit card will cost \$25 per family. If you choose the debit card option the cost will be deducted from your medical reimbursement account.

Debit Card (Self): Please Circle Yes No
 Debit Card (Dependent(s)): Yes No If yes, please provide full name(s)

Spouse: _____ Eligible Dependent (Adult): _____

FSA ELECTION			
(Please indicate your bi-monthly and annual amounts)			
	<u>Reduction Per Pay</u>	<u>Number of Pays (19 / 24)</u>	<u>Annual Amount</u>
A. Health Care	\$ _____	_____ Pays	\$ _____ (\$10,000 Max \$60 Min)
B. Dependent Care	\$ _____	_____ Pays	\$ _____ (\$ 5,000 Max \$60 Min)

I UNDERSTAND THAT I CANNOT CHANGE MY ELECTION AND PAY REDUCTIONS UNLESS I EXPERIENCE A CHANGE IN MY FAMILY STATUS. My employer and I agree that my salary will be reduced by the amount(s) indicated above for the benefit option(s) I have elected under the Flexible Spending Plan. I hereby acknowledge that I have read the Understanding of Agreement.

Further, I hereby consent to the use of my personal identifiable information, and or my dependent(s) information, which I have voluntarily provided on this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, or my dependents' behalf for the sole use of providing benefits, and services related to my account.

This agreement is subject to the terms of the University of Detroit Mercy Flexible Compensation Plan, as amended from time to time, and revokes any prior election and compensation reduction agreement relating to such plan.

 Employee Signature Date _____

 Employer Signature (HR) Date _____

UNDERSTANDING OF AGREEMENTS

I have received the printed material explaining the Plan and my options under the Plan, and I understand that by signing this form, I am making an election which may not be changed for this Plan year other than as permitted by law and the Plan.

I understand that by electing to be covered under the applicable Employer's insurance plan(s), my portion of the premium is automatically reduced from pre-tax wages under the Flexible Compensation Plan, if applicable. Further, I understand that if I do not incur expenses this Plan Year in the amount which I have elected for each benefit, the law requires that I forfeit any unused amounts.

I authorize the reduction of these amounts from my paychecks and acknowledge that these amounts are to be credited to my Flexible Compensation accounts. I authorize the Administrator to draw upon my account to reimburse me for eligible expenses incurred by me during the Plan Year. I understand that request for reimbursement from the reimbursement plan(s) will only be processed if I comply with the terms and conditions of the applicable plan. I also understand that the Plan Administrator and Third Party Claims Administrator may establish rules and procedures from time to time, which also govern processing reimbursement requests. In addition, the Plan Administrator may establish rules and procedures regarding payment of remaining reimbursement contributions upon termination of employment in accordance with the applicable Flexible Benefit Plan Document(s). The Employer and Plan Administrator may take appropriate legal action to assure that reimbursements are made in accordance with the terms and conditions of the reimbursement plan(s).

DEPENDENT CARE

I understand that for this Plan Year, I may be reimbursed for dependent care expenses up to the maximum of (1) Five Thousand Dollars (\$5000), or Two Thousand Five Hundred Dollars (\$2500) if married filing separate, (2) my spouse's earnings, if applicable, or (3) 50% of my earnings, whichever is least. I also understand that in order to receive reimbursement, I must submit receipts or other evidence that indicate who was cared for, dates of service, the actual amount paid along with the name, address and social security/tax identification number or the provider of these services. I understand that I or my spouse, if applicable, may not elect to receive the tax credit for the dependent care expenses that I have been reimbursed for under the Plan.

HEALTH CARE/FSA MEDICAL EXPENSES

I understand that for this Plan Year, I may be reimbursed for expenses incurred for my medical care and the medical care of my spouse and dependents which are not covered by medical insurance or other plans up to the maximum amount deemed by the Plan. The "dependent" relationship must exist when the charges were incurred. If I claim reimbursement for these expenses under the Plan, the amount of the reimbursement will be tax free.

Eligible medical expenses include any expenses incurred for diagnosis, cure, treatment, mitigation, prevention of disease, purpose of affecting any bodily function or structure, prescription drugs, or insulin per IRS guidelines from the "Patient Protection and Affordable Care Act".

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