The University’s Plan Year begins on July 1 and runs through the following June 30.

A flexible spending account ("FSA") allows employees to be reimbursed with pre-tax dollars for qualifying out-of-pocket health care expenses for you and your eligible dependents and/or dependent day care expenses.

Employees may only enroll, change or cancel elections during the Plan Year if they experience a qualified status change event consistent with the requested change. **Eligible changes to an FSA election must be requested within 90 days of the date of the status change event or prior to the end of the Plan Year (June 30), whichever occurs first.**

### HEALTH FLEXIBLE SPENDING ACCOUNT

**Annual Election: $_________________**

I elect the above amount as an annual deferral to the Health FSA on a pre-tax basis (minimum of $5 per paycheck / maximum of $2,600 per Plan Year) to be divided equally among the paychecks I receive during the remainder of the Plan Year. You may request reimbursement for eligible medical expenses incurred on behalf of yourself, your spouse, and your dependent children.

### DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT

**Annual Election: $_________________**

I elect the above amount as an annual deferral to the Dependent Care FSA on a pre-tax basis (minimum of $5 per paycheck / maximum of $5,000 per Plan Year) to be divided equally among the paychecks I receive during the remainder of the Plan Year. **The Internal Revenue Code limits the amount you may defer to a Dependent Care FSA to $5,000 per calendar year per family.**

To estimate your per paycheck deduction, complete the worksheet on the back of this form.

I understand and authorize the following:

- I elect the benefits indicated above and authorize the appropriate payroll deferrals.
- I cannot change my election during the Plan Year unless I experience a qualified status change event and request the change within 90 days of the event date or prior to the end of the Plan Year, whichever is earlier.
- To be eligible, expenses must not be paid, reimbursed, or reimbursable from any other source.
- I forfeit any amounts left in my Health FSA and/or Dependent Care FSA after all eligible expenses are submitted for reimbursement. **(Eligible expenses must be incurred on or before the end of the grace period [September 15] and submitted no later than December 31 following the end of the Plan Year.)**
- If I terminate my employment or transfer to a position not eligible to participate in this benefit, only eligible expenses incurred prior to that date will be reimbursed. I may, however, elect to continue participation through COBRA.
- I must reenroll during open enrollment each year to participate in this benefit during the next Plan Year.
- I am responsible to keep and submit all receipts for reimbursement of unreimbursed health and/or dependent care expenses. If I use my Debit Card for Health FSA purchases, I must retain my receipt; however I will not need to submit my receipt unless asked to verify that the expense was an eligible expense.
- I agree to use my Debit Card for eligible Health FSA expenses that have not already been reimbursed and will not seek reimbursement of those expenses from any other source.

I have read and understand the above information. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize the payroll deductions of amounts elected for the Plan Year.

**Employee Signature: ___________________________  Date: __________________**

**Information and details about FSA accounts are available on the internet at [www.hr.utah.edu/benefits](http://www.hr.utah.edu/benefits) or in the University Human Resources Solutions Center.**

**UHRM Solutions Center: 250 East 200 South, 16th Floor, Salt Lake City, UT 84111**

**Phone: (801) 581-7447, Fax: (801) 585-7375, e-mail: benefits@utah.edu**

**UBenefits: [https://hr.apps.utah.edu/ubenefits](https://hr.apps.utah.edu/ubenefits)**
To estimate your per paycheck deduction, complete the following worksheet. Eligible expenses must be incurred on or before September 15 following the end of the Plan Year (the University’s 45-day grace period).

For information or assistance, contact the UHRM Solutions Center at (801) 581-7447.

<table>
<thead>
<tr>
<th>Health FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Election</td>
<td>$________________________</td>
</tr>
<tr>
<td>Number of Pay Periods Remaining in Plan Year</td>
<td>÷ ___________</td>
</tr>
<tr>
<td>Per Paycheck Deduction</td>
<td>$________________________</td>
</tr>
</tbody>
</table>

**IMPORTANT!**
The per paycheck amount is only an *estimate*. The actual amount will depend on the pay period in which your enrollment is entered into the payroll system.

For details on eligible expenses, reimbursement request forms, and other FSA information, see HealthEquity’s website at [http://learn.healthequity.com/qme/](http://learn.healthequity.com/qme/).