Flexible Spending Account Application

Department Use Only

Employee Name (Last, First) *Please print*

Banner ID

Date of Birth

Street Address

City

State

Zip

Date of Hire

Job Title/Union Affiliation

Day Phone

Email Address

Check one: ☐ 12-Month Employee ☐ 9-Month Deferred Employee ☐ 9-Month Employee ☐ New Hire ☐ Open Enrollment

	Health Care Reimbursement Account	**Dependent Care Reimbursement Account**
	Allows you and your eligible dependents to save tax dollars on health care expenses.	Allows you to save tax dollars on dependent day care expenses.
Minimum Annual Election	**$130**	**$208**
Maximum Annual Election	**$2,650**	The lesser of: **$5,000** for married individuals filing a joint return or for unmarried individuals. **$2,500** for married individuals filing separately. Your earned income. Your spouse's earned income.
Your Annual Election	**$**	**$**

- I authorize my employer to reduce my pay on a per-pay-period basis for the annual amount elected. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event as defined by Internal Revenue Code Section 125 and submit my request within 30 days of that event.
- I am aware of the plan's forfeiture provision and that any amount remaining in my account beyond the defined deadline I will lose.
- I understand that Social Security and Medicare taxes are not being withheld on the amount of the reduction under this election.
- If my employment terminates, only medical expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- When using the debit card, I agree to use the card for eligible expenses only and will submit all itemized receipts.
- Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

Employee Signature

Date

Please return to: HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637, Email: askhr@wayne.edu