UNION COLLEGE
HUMAN RESOURCES
(518) 388-6108

20__ HEALTH/DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

Employee Name: _____ Union College ID #: _____

I. I hereby enroll as a participant in the plan as of January 1, 20__. I authorize my employer to reduce my compensation by the amount specified below in order to purchase benefits under the Plan. I understand that this election is irrevocable during the Plan Year unless the revocation is on account of and consistent with a change in family status.

II. Benefit Election: I elect to allocate the following amounts on an annual and pay period basis for the purchase of the benefits listed below:

	Amount Per Year	Amount Per Pay Period
A. Health Care Flexible Spending Account (Medical, Dental, Vision) - Plan year enrollment 1/1/20__-3/15/20__	_____ *(Max $2,500)*	_____
B. Dependent Care Flexible Spending Account* (Daycare Center, Babysitter, etc.) - Plan year enrollment 1/1/20__-12/31/20__	_____ *(Max $5,000)*	_____
TOTAL	_____	_____

III. From January 1, 20__ to December 31, 20__, my per pay period compensation shall be reduced by amount above to create Health/Dependent Care Flexible Spending Account dollars during the Plan Year. The number of pay periods in this Plan Year, for deduction purposes, is 24.

I understand that all sums remaining in my account as of March 31, 20__ will be forfeited. I further understand that only expenses incurred during the applicable Plan Year and while I am a participant will be eligible for reimbursement.

_____ _____
(Employee Signature) (Date)

* *Expenses must be for dependents under age 13.*