



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__	_____ <i>(Max \$2,650)</i>	_____
B. Dependent Care Flexible Spending Account* (Daycare Center, Babysitter, etc.)		
- Plan year enrollment 1/1/20__-12/31/20__	_____ <i>(Max \$5,000)</i>	_____
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)

\* Annual contribution limit is \$2,500 for single/separate filers; \$5,000 for joint filers or single parent filing as head of household. Expenses must be for dependents under age 13.