

2018 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, 2018. 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 1/1/2018-3/15/2019	_____ <i>(Max \$2,650)</i>	_____
B. Dependent Care Flexible Spending Account* (Daycare Center, Babysitter, etc.) - Plan year enrollment 1/1/2018-12/31/2018	_____ <i>(Max \$5,000)</i>	_____
TOTAL	_____	_____

III. From January 1, 2018 to December 31, 2018, 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, 2019 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.