Flexible Spending Account Enrollment Form

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) - Coverage period: 1/1/20___-3/15/20___	_____ *(Max $2,700)*	_____
B. Dependent Care Flexible Spending Account* (Daycare Center, Babysitter, etc.) - Coverage period: 1/1/20___-3/15/20___	_____ *(Max $5,000)*	_____
TOTAL	_____	_____

III. From January 1, 20___ to December 31, 20___, my per pay period compensation shall be reduced by the 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.