



# Flexible Spending Account Election/Change Form

Department of Human Resources  
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The university's Flexible Spending Account (FSA) program allows current employees to receive pre-tax reimbursement for certain medical, dental, and vision expenses and for qualifying dependent care expenses. Your taxable income reported for both federal and state income tax purposes is reduced by the amount of your FSA contributions. Eligible expenses must be incurred during the period for which you pledge and make FSA contributions.

Effective date \_\_\_\_\_  Paid monthly (01)  Paid bi-weekly (02)

Name \_\_\_\_\_ SSN \_\_\_\_\_  
 Address \_\_\_\_\_ Date of birth \_\_\_\_\_  
 \_\_\_\_\_ Daytime telephone \_\_\_\_\_

**Health Care Account**  
 I wish to enroll in a Health Care Flexible Spending Account. I am authorizing a monthly deduction of \$ \_\_\_\_\_, which is an annual deduction of \$ \_\_\_\_\_. (Maximum monthly contribution is \$500.)

**Dependent Care Account**  
 I wish to enroll in a Dependent Care Flexible Spending Account. I am authorizing a monthly deduction of \$ \_\_\_\_\_, which is an annual deduction of \$ \_\_\_\_\_. (Maximum annual contribution is \$5,000.)

*I acknowledge that I intend to file Form 2441 with the IRS including name, address, and tax ID number of the provider of dependent care services and that if I have elected an FSA contribution of more than \$2,500, that I am either unmarried or, if married, that I do not intend to file a separate federal tax return.*

*I authorize my employer to deduct the amount pledged from my salary, with the understanding that Wright State University acts as my agent in all dealings with the Plan and that all acts performed by and all notices given to Wright State University is binding upon me, as not prohibited by statute or regulation.*

\_\_\_\_\_  
Employee Signature Date

### Health Care Flexible Spending Account

This account is for medical, dental, and vision care expenses which are not reimbursed by a health insurance plan. These expenses include copayments, deductible expenses, and items not covered by insurance.

*You will not be reimbursed for cosmetic surgery or cosmetic dentistry not necessary to improve a deformity or not directly related to birth defect, personal injury, or a disfiguring disease. Other common items not covered by an FSA are Rogaine for treatment of baldness, teeth bleaching, contact lens replacement insurance premiums, weight loss programs/drugs, Retin A for wrinkles, electrolysis, quit smoking programs, and message therapy, unless prescribed by a physician for a medical diagnosis. The minimum monthly contribution is \$10, and the maximum is \$500.*

### Dependent Care Flexible Spending Account

This account is for child and other dependent care expenses that allow you and your spouse, if you are married, to work or attend school full-time. The expenses must be for a child under age 13 or physically or mentally disabled dependent at any age who lives with you at least eight hours a day. The individual must be claimed as a dependent on your federal income tax return. Claims must include the following information:

Period during which the services were rendered; amount paid; name, address, and tax ID (or SSN) of the provider; and written acknowledgement of services provided by provider (receipt)

*Cancelled checks and credit card receipts are not acceptable documentation.*

The minimum monthly contribution is \$10, and the maximum annual contribution is \$5,000.

### General Information Pertaining to Both Accounts

Your FSA election is effective for the remainder of the calendar year of election. You can not change the amount of your FSA election or stop FSA contributions during the year unless you experience a qualifying change in family status such as the birth of a child, marriage, divorce, death of your spouse or child, or a change in you or your spouse's employment. Changes to your FSA elections must be consistent with the family status change.

**Expenses claimed for reimbursement must be incurred in the period for which you pledged and made FSA contributions. Requests for FSA reimbursement must be filed by March 31 of the year following the year of your FSA elections.**

For employer use

Reason for change \_\_\_\_\_ Date \_\_\_\_\_