



UNIVERSITY OF RICHMOND

2008 MEDICAL & DEPENDENT CARE & QTE Reimbursement Enrollment Form (For reimbursement of qualified medical, dependent care & QTE expenses incurred by the employee and/or his/her dependents from January 1 through December 31, 2008)

To be completed by the Employee (please print clearly):

Employee Information			
Name: _____		Date of Birth: _____	
Last	First	Middle	
Social Security #: _____		University ID #: _____	
Home Address: _____			
Street Address		Apartment Number	
City		State	Zip Code
E-mail Address: _____			
Number of annual paychecks (calendar year January – December):			
• BI-WEEKLY* pay checks from which benefits will be deducted (CIRCLE ONE):		24	Other: _____
OR			
• MONTHLY paychecks you receive (CIRCLE ONE):		9 10 12	Other: _____
Department: _____		Phone Extension: _____	
Health Flexible Spending Account			
I elect to participate in the Medical Reimbursement program. I understand that money will be deducted from my biweekly* or monthly paycheck in equal amounts throughout the plan year (January – December) on a before-tax basis.			
<i>Annual Amount</i> (maximum \$5,000/year, minimum \$100/year) \$ _____		Per Pay Check \$ _____	
Dependent Care Flexible Spending Amount			
I elect to participate in the Dependent Care Reimbursement program. I understand that money will be deducted from my biweekly* or monthly paycheck in equal amounts throughout the plan year (January – December) on a before-tax basis.			
<i>Annual Amount</i> (maximum \$5,000/year, minimum \$100/year) \$ _____		Per Pay Check \$ _____	
QTE Flexible Spending Account			
I elect to participate in the QTE Reimbursement program. I understand that money will be deducted from my biweekly* or monthly paycheck in equal amounts throughout the plan year (January – December) on a before-tax basis.			
<i>Per Pay Check Deduction</i> (monthly transit max \$110/mth)		Per Pay Check \$ _____	

*Employees on the biweekly payroll will have benefits deducted from 24 of the 26 paychecks.

Authorization

I have read The Summary Plan Description provided by the above mentioned employer and hereby choose to participate as shown above. I agree to a per pay period reduction during the plan year referenced above for the amounts indicated. I understand that this election is binding for the plan year and that changes are only permitted in case of a change in family status or spouse's employment.

Employee Signature

Date