



UNIVERSITY OF RICHMOND

2017 MEDICAL & DEPENDENT CARE Reimbursement Enrollment Form (For reimbursement of qualified medical and dependent care incurred by the employee and/or his/her dependents from January 1 through December 31, 2017)

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

Employee Information			
Name: _____		Date of Birth: _____	
_____ Last	_____ First	_____ Middle	
University ID #: 0 _____		E-mail Address: _____	
Home Address: _____			
_____ Street Address		_____ Apartment Number	
_____ City		_____ State	_____ Zip Code
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 \$2,600/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 \$ _____			

*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