UNIVERSITY OF RICHMOND

2020 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, 2020.)

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.

Annual Amount (maximum $2,700/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.

Annual Amount (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