AUBURN UNIVERSITY FLEXIBLE SPENDING ACCOUNT PLAN
OPEN ENROLLMENT FORM FOR 2018 PLAN YEAR

Name_____ Employee ID#_____
(Please Print) **(Available on Pay stub)**

Home Address:_____City_____State_____Zip Code_____

Home Phone No:_____ Date of Birth:_____ Date of Hire:_____

Marital Status: Married _____Single_____ Email address:_____

The Option to Reimburse Claims by Direct Deposit will be available to you once you are registered with the FSA vendor WageWorks.

I am paid: A. Monthly: 12 Paychecks_____ B. Semi-Monthly: 18 Paychecks_____ C. Biweekly: 26 Paychecks_____

Medical Reimbursement Account

Minimum annual amount is $60. **Maximum annual amount is $2,600 per Employee**
(See List of Eligible Medical Expenses & Certain over the Counter Medications at www.auburn.edu/payroll)

Non-Fixed Expenses **Annual Amount** $_____

Dependent Care Reimbursement Account

Maximum annual amount is $5,000 per household (unless married and filing separately: $2,500). You can use this account for **reimbursement of daycare expenses (child/elder (spouse) care** if you are married and both you and your spouse work outside the home, or if your spouse is a full time student.

Non-Fixed Expenses **Annual Amount** $_____

TOTAL ANNUAL AMOUNT $_____

I authorize my employer to reduce my **gross pay** each pay period by the amounts needed to total my **annual elections** starting with January 1, 2018 through December 31, 2018. The employer hereby agrees to allocate the monies as directed herein above.

Furthermore, I understand that: **I cannot change this election** during the plan year, unless the change is due to a change in my family status (e.g., marriage, divorce, childbirth, and spouse employment change, death of spouse or dependent), my termination of employment, or a change in dependent care payments which is beyond my control. Each of my children is now eligible for coverage through the end of the Plan Year in which he or she attains age 26 as an Adult Child.

I cannot transfer money between the reimbursement accounts and any money in my dependent care account not used to pay expenses incurred during the plan year will be forfeited. **All claims and receipts for expenses claimed for the previous plan year must be submitted within 90 days after the end of the current plan year to WageWorks for reimbursement with prior year funds.**

In the Medical Reimbursement Account, funds up to $500 left from the prior plan year may be "Carried Over" to the new plan year and may be used once current year funds are depleted. Any monies left over the $500 for that plan year will be forfeited.

The employer may terminate this plan at any time. **I will retain all receipts and documentation** from flexible spending transactions to prove expenses are eligible under the plan guidelines and applicable regulations established by Internal Revenue Service. I am aware that I am obligated to submit Flex debit card transaction receipts and/or other related claim information and documentation as deemed necessary to substantiate the eligibility status of the service /purchase. Failure to submit such documentation may result in: 1) the expense being deemed ineligible in which case I would be obligated to repay the amount to the plan and/or 2) immediate suspension or revocation of the Card; and/or 3) taxable payroll deductions by my employer of the ineligible expense. I authorize the use of my e-mail address for plan correspondence.

If I am a current year participant and I re-enroll for 2018, I understand my 2018 election amount for medical reimbursement account will be automatically loaded to my current FSA debit card. If I am a new participant, I understand I will receive a new 2018 WageWorks Health Care debit card from the FSA vendor WageWorks. It is my responsibility to order new debit cards for my dependent/s by accessing my account at WageWorks or calling WageWorks at 877-924-3967.

_____ _____
Employee's Signature Date Signed