UNIVERSITY OF ARKANSAS SYSTEM

FSA ENROLLMENT FORM

A Flexible Spending Account (FSA) is a benefit provided by your employer that allows you to set aside pre-tax dollars at the beginning of the plan year to pay for out-of pocket eligible health care and dependent care expenses. Please complete ALL APPLICABLE FIELDS and return this form to your Human Resources Office.

Plan Year: January 1 through December 31 YEAR _____

SECTION I. EMPLOYEE INFORMATION. Please print legibly in blue or black ink.

Full Name *(LAST, FIRST, MI)*		**Date of Birth** (MM/DD/YYYY)		**Social Security No.**
Street Address	**City**	**State**	**Zip**	**Phone No.**

PAYROLL CYCLES

☐ Bi-Weekly (_____Pay Periods) ☐ Semi-Monthly (_____Pay Periods) ☐ Monthly (_____ Pay Periods)

CONTRACT PERIOD (Please check one):

☐ 12 Months ☐ 10½ Months
☐ 10 Months ☐ 9 Months

CAMPUS (Please check one):

☐ ASMSA ☐ CES ☐ UAF ☐ UACCB ☐ UALR
☐ UAM ☐ UAMS ☐ UAPB ☐ WRI ☐ PCCUA

☐ Other: _____

SECTION II. ELECTION INFORMATION

ELIGIBLE EXPENSES	**Per Plan Year** Amount you will contribute for the entire plan year
HEALTH CARE ACCOUNT Not to exceed $5,000. Include health care expenses for you and your eligible dependents. DO NOT INCLUDE INSURANCE PREMIUMS.	$_____
DEPENDENT CARE ACCOUNT (DAYCARE) Is the least of: your salary, your spouse's salary, $5,000 annually (if married filing a joint return or single filing head of household); $2,500 annually (if married filing separate returns), or your expenses.	$_____

SECTION III. AUTHORIZATION AND SIGNATURE (PLEASE READ BEFORE SIGNING IN INK)

1. I hereby authorize my employer to make periodic salary reductions from my paycheck, to be deposited in my account, for the Plan Year specified above in an amount equal to the specific dollar amounts elected for my Health Care Account and Dependent Care Account.
2. The salary reductions shall be made in substantially equal amounts to the extent administratively feasible.
3. I further authorize QualChoice (the UA Flexible Spending Account Administrator) to disburse funds from my account in accordance with the plan and my elections. I understand that my elections cannot be altered without a qualified "Change in Status" or "Exception".
4. I understand that changes in my Health Care Account elections will only be permitted by reason of "Change in Status" as listed on ***FSA Change Form***, and that I must make my new election within 31 days of the "Change in Status".
5. If my FSA debit card is not used, I understand that I must submit an ***FSA Claim Form*** to receive reimbursement from my Health Care Account.
6. I understand that all requests for reimbursement must be received by QualChoice no later than **March 31** of the following plan year.
7. I verify that, if I have elected to make salary reduction contributions for the Dependent Care benefit in an amount that will not exceed $5,000 in one calendar year, and if I am married, I will file a joint income tax return with my spouse.

Signature of Employee **X**	**Date Signed**

RETURN THIS FORM TO YOUR HUMAN RESOURCES OFFICE.

Copy Distribution: White & Yellow – Human Resources ▪ Pink – Employee

For Office Use Only
FSA Effective Date: _____

☐ New Hire/Newly Eligible as of_____
☐ Plan Year Open Enrollment

QualChoice®