Flexible Spending Accounts Enrollment Form - 2024

Kent State Employee Benefits – 330-672-3107

Employee Name (PLEASE PRINT) _____ BANNER ID _____

DEPARTMENT _____ PHONE _____

Employee Type: ☐ Classified ☐ Unclassified ☐ Faculty

NOTE: **This election is made for a CALENDAR YEAR (January 1 – December 31)**. This election is NOT made on an academic year or fiscal year (July 1 – June 30) basis. Your election cannot be changed during the calendar year unless you have a qualifying change in status as defined by the Internal Revenue Code.

Health Care Flexible Spending Account

This pays for qualified out-of-pocket health care expenses for myself and qualified dependents that are not covered by my employer's health plan or any other health plan.

Please indicate if you wish to participate in the Health Care Flexible Spending Account, and the amount you wish deducted from your pay.

☐ I choose to participate in the Health Care Flexible Spending Account. My total deposit for this year is $_____. I understand this total will be deducted from my pay in equal amounts from each month in which I receive base pay during the year. (Please enter a whole dollar amount between $120 and $2,850)

Dependent Care Flexible Spending Account

This pays for day care expenses for a dependent child, adult or elder, so that you may work. Eligible services include: nursery school, nanny and/or before/after school care through age 12, day care for a disabled adult or child, elder day care for parent or dependent, day camp through age 12.

Please indicate if you wish to participate in the Dependent Care Flexible Spending Account and the amount you wish deducted from your pay.

☐ I choose to participate in the Dependent Care Flexible Spending Account. My total deposit for this year is $_____. I understand this total will be deducted from my pay in equal amounts from each month in which I receive base pay during the year. (Please enter a whole dollar amount between $120 and $5,000)

I understand that my taxable income will be reduced each pay period during the year by an equal portion of the annual amount elected above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election only in the event of certain changes in my status and during annual open enrollment. I understand that the *Flexible Spending Account card* is available to pay only qualified expenses. I understand that qualified expenses paid with my *Flexible Spending Account card*, or any other form of reimbursement, cannot be reimbursed by any other plan and I will not seek reimbursement from any other source. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions. ***I understand I must keep all receipts when using the Flexible Spending Account card and that, on occasion, I may be asked for documentation of charges made with my Card.*** I acknowledge that I will forfeit any unused balance remaining in my Flexible Spending Account(s) at the end of the reimbursement period. I understand that if I separate employment from the University, I must submit all claims for reimbursement within 30 days of my separation.

Signature _____ Date _____

Effective Date: _____

This form must be submitted to Employee Benefits at Heer Hall – Kent Campus.