

Please return completed form to your employer.

EMPLOYEE INFORMATION

EMPLOYER [ ] PLAN EFFECTIVE DATE [ ]
EMPLOYEE'S NAME [ ] BIRTHDATE [ ]
SOCIAL SECURITY OR MEMBER ID NUMBER [ ] GROSS ANNUAL SALARY [ ]
MAILING ADDRESS [ ]
CITY & STATE [ ] ZIP CODE [ ]
HOME PHONE [ ] WORK PHONE [ ]
E-MAIL ADDRESS [ ]

NON-PARTICIPATION WAIVER

I understand that I am eligible to participate in the Flexible Spending Account program, but elect not to do so at this time. I also understand that I may participate in the Flexible Spending Account program during the next available enrollment period.

Employee Signature

Date

CONTRIBUTIONS AGREEMENT

MY PAYROLL PERIOD IS [ ] MONTHLY [ ] BIWEEKLY [ ] SEMI-MONTHLY [ ] OTHER [ ]

Amounts entered below reflect the deduction to be taken PER PAY PERIOD. Divide any annual fees\* by the number of pay periods per year.

HEALTH CARE (medical, dental, vision) \$ [ ]
DEPENDENT CARE (child, elderly) \$ [ ]
ADMINISTRATIVE FEE (select one) \$ [ ]

I authorize Weber State University to deduct my insurance premiums on a [ ] pre-tax [ ] post-tax basis. [ ] initial

[ ] WITH BENNY CARD
[ ] WITHOUT BENNY CARD

TOTAL DEDUCTION PER PAY PERIOD \$ [ ]

Automatic reimbursement is an option for employees who do not have coordination of benefits or the Benny Card. If eligible, do you want your processed EMIA claims automatically reimbursed?

[ ] YES [ ] NO

DEDUCTIONS AGREEMENT

I hereby request enrollment in the Flexible Spending Plan. I authorize my employer, until this authorization is revoked in writing due to a change in employment or family status, to reduce my gross salary by the amount shown above. I understand that amounts contributed to the FSA are subject to forfeiture procedures under Section 125 of the Internal Revenue Code.

Employee Signature

Date

Employer Signature

Date

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