

# INDIANA STATE UNIVERSITY FLEXIBLE SPENDING ACCOUNT

## Enrollment Application

**EMPLOYEE:**

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

Email Address \_\_\_\_\_ Department \_\_\_\_\_ Extension \_\_\_\_\_

Male  Female  Single  Married Date Employed \_\_\_\_\_

Employment Class:  Faculty  Exempt  Non-Exempt University ID # \_\_\_\_\_

Date of Birth \_\_\_\_\_ FSA Effective \_\_\_\_\_

**SPOUSE:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Participation in the Flexible Spending Account (FSA) reduces compensation by the total annual election.**

**I understand:**

- \*Contributions for this plan are taken before taxes are calculated. These funds help you pay for qualifying medical or dependent care expenses with pretax dollars.
- \*these contributions reduce wages for Social Security purposes and may reduce Social Security disability/retirement benefits,
- \*contributions will not earn interest in the FSA account,
- \*the annual election can only be changed during open enrollment for the following year or with a change in family status, as determined by IRS regulations. Such changes must be made within 30 days after the qualifying event,
- \*over the counter drugs are ONLY allowed as reimbursable items with a written prescription from your physician. Please take this into consideration when determining your annual spending account election.

**Please read carefully!**

The Run-Out Period for claims incurred during 2017 but submitted for reimbursement later must be done by **April 28, 2018**.  
**A Grace Period** will allow funds left in the FSA on December 31, 2017, to be used for expenses incurred in the first 2 ½ months of 2018 (through March 15, 2018). The FSA debit card **CANNOT** be used for these charges. The deadline to submit these claims is **April 28, 2018**

**Please Note:**

- \*The decision to enroll in a flex plan must be done on this form each year. The amount will not carry forward to the next year.
- \*For 2017, the medical FSA yearly maximum contribution is limited to \$2,600. The maximum yearly FSA contribution for dependent care remains \$5,000.

**2017 Flexible Spending Account Election:**

**Total Annual Election:** Medical Account \_\_\_\_\_ Dependent Care \_\_\_\_\_

**Your annual election will be divided by the number of regular pays you will receive during the year.**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

(Typing your name here acts as your signature in an electronic version)

**Staff Benefits Use**

#Pays _____	Effective Date _____	Cancel Date _____	
1st Pay FSA\$ _____		DCAS\$ _____	
Rem PAY FSA\$ _____		DCAS\$ _____	
Total FSA\$ _____		DCAS\$ _____	