Clear Form

INDIANA STATE UNIVERSITY
FLEXIBLE SPENDING ACCOUNT
Enrollment Application

EMPLOYEE:

Name _____

Address _____ **Telephone Number** _____

Email Address _____ **Department** _____ **Extension** _____

☐ **Male** ☐ **Female** ☐ **Other** ☐ **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!

Claims incurred during 2019 must be submitted for reimbursement no later than April 29th, 2020.

A Grace Period will allow funds left in the FSA Medical on December 31, 2019, to be used for expenses incurred in the first 2 ½ months of 2020 (through March 15, 2020). The FSA debit card CANNOT be used for these charges. The deadline to submit these claims is April 29th, 2020.

Please Note:

*You must be enrolled in the PPO Health Plan to be eligible for the Medical FSA Account

*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 2019, the medical FSA yearly maximum contribution is limited to $2,650. The maximum yearly FSA contribution for dependent care is $5,000.

2019 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)

Employee Benefits Use

#Pays_____ Effective Date_____ Cancel Date_____

1st Pay	FSA$_____	DCA$_____
Rem PAY	FSA$_____	DCA$_____
Total	FSA$_____	DCA$_____