

**UNREIMBURSED HEALTH CARE
FLEXIBLE SPENDING ACCOUNT ELECTION FORM**

I have read the information on the Unreimbursed Health Care Flexible Spending Account. I understand that I have the option to reduce my salary to reimburse myself for unreimbursed health care expenses I may incur in the coming year.

I understand that I may elect to reduce my salary up to any amount per year for the Unreimbursed health Care Flexible Account for the Plan Year ending December 31, _____. On the back of this form is a Health Care Account Worksheet to help you estimate your expenses. **NOTE: ANY AMOUNT DEDUCTED DURING THE PLAN YEAR, FOR WHICH CLAIMS ARE NOT MADE, WILL BE FORFEITED.**

I elect to reduce my salary by \$_____ per period (10, 12, 26 pay periods). This amount will reduce my yearly salary by \$_____ for the period of January 1, _____ through December 31, _____.

I understand that I will not be permitted to change this election until January 1, _____ except for 30 days after the following changes in circumstances:

Marriage or Divorce

Birth, Adoption, or Death of a child

The Death or Change in Employment Status of my Spouse

Finally, I understand that if I should terminate employment before December 31, _____ My salary reduction election will cease to be effective on the day I terminate my employment.

Date

Signature

Social Security Number

Name Printed

Department

Received By

