



1975 Tamarack Road P.O. Box 1096  
Newark, OH 43058-1096 (800) 297-1829

## FLEXIBLE SPENDING PLAN (FSA) COMPENSATION REDIRECTION AGREEMENT

**PLEASE READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR PARTICIPATION FROM BEING DELAYED**

Employee Information (Please Print in Ink):

Name _____ <small>Last First Middle Initial</small>	Social Security Number _____
Home Address _____ <small>Street City State Zip</small>	
Telephone ( ) _____	

Employee Date of Birth ____/____/____ <small>Mo. Day Yr.</small>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Date Hired ____/____/____ <small>Mo. Day Yr.</small>
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Payroll Cycle <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	Location Number _____	First Pay Cycle Deduction(s) will be taken ____/____/____ <small>Mo. Day Yr.</small>	Effective Date on FSA Plan ____/____/____ <small>Mo. Day Yr.</small>
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Employed by <b>ANTIOCH UNIVERSITY</b> <small>Company Name</small>	10225 <small>Group/Account Number</small>
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**LIST DEPENDENTS WHOM YOU WILL BE CLAIMING EXPENSES FOR BELOW**

Full Name	Date of Birth	Sex		S.S. Number ( <i>Spouse Only</i> )					You &/or your Spouse provide over 50% of Support? <small>Yes / No</small>	Full-Time Student? (Y/N)
		Male	Female							
<b>Spouse</b>										
<b>Other Dependent(s)</b>										

\*Are you (Employee) covered or insured under any other medical or dental coverage (including Medicare and other government plans)?  
 Yes  No If yes, please indicate who the carrier is: \_\_\_\_\_

\*Is your Spouse covered or insured under any other medical or dental coverage (including Medicare and other government plans)?  
 Yes  No If yes, please indicate who the carrier is: \_\_\_\_\_

\*Are your Dependents covered or insured under any other medical or dental coverage (including Medicare and other government plans)?  
 Yes  No If yes, please indicate which dependents are covered and who the carrier is: \_\_\_\_\_

**PLEASE BE SURE TO COMPLETE THE BACK OF THIS FORM TO PREVENT A DELAY IN PROCESSING YOUR ENROLLMENT**

**FULL HEALTH CARE SPENDING ACCOUNT** (Employee and/or Dependent Medical, Prescription, Dental, Eye Care Expenses - not reimbursed by Insurance- **this option is NOT available for those individuals enrolled in the HSA Plan**)

**this option is NOT available for those individuals enrolled in the Health Savings Account (HSA) Plan**

Per Pay Contribution \$ \_\_\_\_\_

Total Annual Contribution \$ \_\_\_\_\_  
(\$ 4,000.00 Maximum)

**LIMITED PURPOSE HEALTH CARE SPENDING ACCOUNT** (Employee and/or Dependent DENTAL and VISION ONLY expenses) **this option is ONLY available for those individuals enrolled in the HSA Plan**

**this option is ONLY available to those participants enrolled in the Health Savings Account (HSA) Plan**

Per Pay Contribution \$ \_\_\_\_\_

Total Annual Contribution \$ \_\_\_\_\_  
(\$4,000.00 Maximum)

**PREMIUM REIMBURSEMENT ACCOUNT** (Individual Insurance Premiums)

Per Pay Contribution \$ \_\_\_\_\_

Total Annual Contribution \$ \_\_\_\_\_  
(\$3,000.00 Maximum)

**DEPENDENT CARE SPENDING ACCOUNT** (ONLY work-related child and/or Adult Day Care Expenses)

Per Pay Contribution \$ \_\_\_\_\_

Total Annual Contribution \$ \_\_\_\_\_  
(\$5,000 Maximum; \$2,500 if married and filing separate income tax return)

**Read this Statement and Authorization Carefully**

I agree that my Compensation will be reduced by the amount of my required contribution for the Benefits that I have elected under the Plan and that such Compensation Redirections will continue for each pay period until this Agreement is amended or terminated. I understand the following:

- Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
- I understand that the amounts deducted from my pay and not used for eligible health care and/or dependent care expenses incurred within the same year **will be forfeited** in accordance with IRS regulations.
- I understand that I cannot change or revoke this Election once the Plan Year has begun unless I have an IRS qualifying change in status.

Qualifying change in status events must be submitted to the Human Resource Department within the first thirty (30) days of the date of the event. A photographic copy of this authorization shall be as valid as the original. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent above.

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

**WARNING:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer or health benefit plan, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.