

Brandeis University

Office of Human Resources
Benefits Section · MS 118 · 781-736-4468

Flexible Reimbursement Account Enrollment / Change / Cancellation Form for Plan Year 2010

Employee Information

Name: _____

Department: _____

Hire Date: _____

Mailstop: _____

Ext: _____

Please select:

(Check one)

Pay Cycle: Weekly (48 pay periods/year) Semi-Monthly (24 pay periods/year)

Staff []

Will you be **unpaid** over any of the Summer months, scheduled to work **less than 52** weeks/year, or scheduled to take an **unpaid** leave during the Spring or Fall? Yes No

Faculty []

If yes, how many paychecks do you estimate you'll receive in the calendar year?

Flexible Reimbursement Account Information

Health Care Account

Enrollment Change Cancellation

\$ _____

Amount to be deducted for the plan year 2010*

* Minimum amount is \$200/year

* Maximum amount is \$4,000/year

Dependent Care Account

Enrollment Change Cancellation

\$ _____

Amount to be deducted for the plan year 2010*

* Not to exceed a maximum of \$5,000 if you are filing taxes as single or married filing jointly or \$2,500 if you are married filing separately.

Acknowledgement/Signature

In making this election, I understand and agree that:

1. I can receive reimbursement only for qualified expenses incurred from date of enrollment through December 31, 2010 or the date I am no longer an eligible employee.
2. Any unused amount remaining in my Flex Dependent Care Reimbursement Account will be forfeited.
3. If I receive reimbursement for expenses that are not eligible, or if the IRS rules that the Flex Account does not meet the requirement for reducing taxable income, I agree to reimburse the University for any liability it may incur for failure to withhold Federal and State income tax or Social Security tax, up to the amount of additional tax actually owed by me, including interest and penalties.
4. Brandeis University cannot guarantee the tax treatment of Flexible Dependent Care Reimbursement Account deposits as described in the Flexible Dependent Care Reimbursement Account Summary Plan Description.
5. I cannot change or revoke this agreement during the plan year unless certain changes in my status as described in the Flexible Health Care Reimbursement Account Summary Plan Description and/or the Flexible Dependent Care Reimbursement Account Summary Plan Description occur.
6. The Plan Administrator may reduce or cancel my salary reduction agreements if he/she considers it advisable in order to satisfy provisions of the Internal Revenue Code.

I have read, understand, and agree to all provisions of the plan as described in the *Flexible Health Care Reimbursement Account Summary Plan Description* and/or the *Flexible Dependent Care Reimbursement Account Summary Plan Description*.

Employee Signature

Date

For Internal Use only

Health FSA: # Paychecks per Year _____ / Total Reductions for 2010 = \$ _____ per month

Dependent FSA: # Paychecks per Year _____ / Total Reduction for 2010 = \$ _____ per month

Accepted and agreed to by Brandeis University. Your Flexible Spending Account(s) will be effective from _____ 1, 2010 to December 31, 2010.

Benefits Coordinator Approval

Date