



FSA Enrollment Form



PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: Western Michigan University Employee ID Number: _____

Participant First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Calendar Year: _____

E-mail Address: _____ (Notification of direct deposit payments are only sent via e-mail)

Pay Period: Semi-Monthly (twice a month) Bi-Weekly (every other week)

MEDICAL REIMBURSEMENT ACCOUNT

I elect to participate \$_____ Annual Pledge Total (may not exceed employer limit of \$2,650)
Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

I elect NOT to participate Mid-Year election or change

DEPENDENT CARE ACCOUNT

I elect to participate \$_____ Annual Pledge Total (may not exceed \$5000 or \$2500 if married filing separately)
Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

I elect NOT to participate Mid-Year election or change

DIRECT DEPOSIT

Use account information on file Use account information below No Direct Deposit
 Checking account OR Savings account
 I elect NOT to participate

Financial Institution: _____

Routing Number: _____ Account Number: _____

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my Dependent Care Reimbursement account(s) at the end of the plan year will be forfeited. I further understand that any unused funds up to \$500 remaining in my Medical Reimbursement Account will be rolled over to the next calendar year and any unused funds in excess of \$500 will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

Submit form to Western Michigan University Human Resources
Campus Location: 1300 Seibert Administration Building, Mail Stop 5217
Mail: 1903 W. Michigan Ave. Kalamazoo, MI 49008-5217
Fax: 269-387-3441

HR USE	Please complete for mid-year enrollments	Eligibility date: _____
	\$ _____ X _____ = \$ _____	Date of first deduction: _____ Benefit Program: _____

TEAR ALONG THIS LINE