



2023

# Flexible Spending Account 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 payments are sent via e-mail.)

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

## HEALTHCARE FLEXIBLE SPENDING ACCOUNT

- I elect to participate \$ \_\_\_\_\_ Annual Pledge Total (may not exceed employer limit of \$3,050) *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 FLEXIBLE SPENDING 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

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 \$550 remaining in my Medical Reimbursement Account will be rolled over to the next calendar year and any unused funds in excess of \$550 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: 1270 Seibert Administration Building, Mail Stop 5217  
Mail: 1903 W. Michigan Ave. Kalamazoo, MI 49008-5217  
Fax: 269-387-3441

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