FSA Enrollment Form

Western Michigan University
Human Resources

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 $2,700)
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 calender 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

$_____ X _____ = $_____

Please complete for mid-year enrollments

Date of first deduction: _____

Eligibility date: _____

Benefit Program: _____