

# Flexible Benefit Plan (Healthcare & Dependent Care FSA)

Plan Year: July 1, 2009 – JUNE 30, 2010

## Election Form and Pre-Tax Salary Reduction Agreement

I. Employer Name: BALL STATE UNIVERSITY Plan Year: 7/01/2009 – 6/30/2010

Employee Name: \_\_\_\_\_  
(Please Print) FIRST MI LAST

Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
CITY ST ZIP Date of Birth: \_\_\_\_\_

E-mail: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_

II. Pursuant to my Employer's Flexible Benefits Plan ("Plan"), I elect to have my salary reduced by the total pre-tax amount specified below. I authorize Ball State University to apply that amount toward those plan benefits listed on this form. I have read and understand the rules and restrictions of participation.

Healthcare Flexible Spending Account: \$ \_\_\_\_\_ FSA Deduction Per Pay Period  
\_\_\_\_\_ # of Payroll Deductions  
\_\_\_\_\_ **Health Care FSA PLAN YEAR Total**

**Important notice to High Deductible HSA PPO (HDHSA) Participants:** The use of a Healthcare Flexible Spending Account (Healthcare FSA) is not permitted when you also contribute to a Health Savings Account (HSA) except for certain "limited-uses" that are defined by the IRS. "Limited uses" may include vision, dental, IRS-defined preventive care goods and services, and HDHSA out-of-pocket costs exceeding the HDHSA deductible. The HDHSA participant is solely responsible for filing only eligible claims under this "limited-use" FSA provision. Any HDHSA participant that would like to utilize a Healthcare FSA (and not contribute or otherwise participate in an HSA) must notify the Payroll & Benefits Office in writing prior to his/her FSA participation start date (July 1). See your FSA plan document for details or contact Key Benefit Administrators at 1-800-558-5553 with questions.

Dependent Day Care Flexible Spending Account: \$ \_\_\_\_\_ FSA Deduction Per Pay Period  
\_\_\_\_\_ # of Payroll Deductions  
\_\_\_\_\_ **Dependent Day Care FSA PLAN YEAR total**

III. **I UNDERSTAND AND AGREE THAT:**

1. I will have the full annual max available to me (\$5000 per account) if desired and applicable for my family status in the Plan Year period so long as I do not exceed the IRS maximum contribution permitted in a calendar (tax) year. (Employees who are hired later in the Plan Year will have a short plan year calculated based upon their specific date of eligible employment.)
2. I cannot change or revoke my election until the next Plan Year unless my Status changes (as defined in my Employer's Plan). I understand my benefit elections may not be reduced below the amount that has been taken pre-tax as of the date of the status change.
3. Any funds remaining in my FSA at the end of the plan year will be forfeited by IRS regulations to my employer.
4. If my employment terminates for any reason, I understand expenses must be incurred while covered and on or before my termination date. I will still have 90 days to submit claims. I agree to not attempt to utilize my Healthcare FSA debit card following my last date of employment.
5. I understand that any receipt I submit must be for an eligible expense incurred during the specific Plan Year, subject to the plan's grace period provision.
6. Before the first day of each Plan Year, I will be offered the opportunity to enroll for the next Plan Year if I remain in an eligible status. Participation does not continue without re-enrollment each Plan Year and my account nor any balance in my account at the end of a Plan Year does not "roll-over" to the next Plan Year.
7. My Employer may reduce or cancel the election of any non-taxable benefit or otherwise modify my election in accordance with the Plan if my Employer in its discretion, deems that action advisable to satisfy the requirements of the IRS code or the regulations thereunder & based upon a calendar (tax) year.
8. By signing and using the **mbi Benefits Card** debit card (the Card), if so provided by my employer, I accept responsibility that all Card transactions will be solely for qualified expenditures incurred within the Plan Year. Each time I present the Card for payment, I will sign a receipt evidencing that the expense has been incurred and reaffirming that it is a qualified expenditure that has not been reimbursed, nor will any reimbursement be sought from any other source. Upon request, I will immediately submit any required documentation and/or transaction detail. I understand that if I use the Card for purchases other than qualified expenditures, I have violated this Agreement and my obligations under my Employer's Plan. I understand that, upon notification, I must immediately repay the expense to the Account and that my Card may be immediately suspended or revoked for such failure to comply.
9. I understand that I am only eligible to make FSA contributions during those months in which I meet IRS-defined eligibility requirements and I agree to notify my employer immediately in writing if I cease to meet any of these eligibility requirements.

Employee Signature

Instructions

Date

# Flexible Benefit Plan (Healthcare & Dependent Care FSA) Election Form Plan Year (7/1/09 – June 30, 2010)

**\*\*Please print all information requested except signature.\*\***

## Section I

**Name:** Please complete your name as it appears on your payroll record. If you have had a name change, you should speak with the PEB receptionist to update your record.

**Address:** Your current home address.

**SSN:** This is a required field due to IRS regulations.

**Date of Birth:** Your date of birth.

**Email address:** Our claims administrator, Key Benefits (KBA) will use this address to request verification of the Debit Card (for Healthcare FSA participants only).

**Daytime phone #:** Your contact number where you are most accessible during the normal business day.

## Section II

**FSA Deduction Per Pay Period:** This is your “Plan Year Total” divided by your # of pays in 2009/10 plan year.

**Number of Payroll Deductions:** This will vary with your job classification and how frequently you are paid during the months of July 1, 2009 through June 30, 2010. The following chart should help you determine the number that applies to you. You will want to divide the “Plan Year Total” by this number to determine the “per pay” dollar amount. Remember that you should only designate deductions that cover your expenses for the July 1, 2009 through June 30, 2010 period and you may not exceed a total of \$5,000 per account during any CALENDAR YEAR (tax year) period.

<u>Job Classification</u>	<u>Max # of deductions during 2009/10Plan Year</u>
Faculty	10
Professional/Exempt Staff	12
Non-Exempt 12 Month Staff	26
Non-Exempt 10 Month Staff	18

**FSA Plan Year Total:** This is the total amount you estimate you can spend during the Plan Year and wish to have withheld pre-tax from your paycheck during the Plan Year of 2009/10. If you have questions about how much you can contribute, please review the FSA Employee Tax Savings Worksheet on the PEB website or contact PEB at 285-8461. It is important that you estimate carefully.

**Note:** The maximum you can withhold for Healthcare and Dependent Care FSA's is \$5,000 each during a calendar (tax) year.

## Section III

**Signature:** Please sign, date, and submit your form to the Office of Payroll & Employee Benefits, AD 029.

Your completed and signed election form must be received no later than 4pm, Friday, May 29, 2009 OR within 31 days from your date of employment or “qualifying event”. A “qualifying event” such as birth of a child, marriage, a spouse’s loss of employment, etc. may permit certain changes to your elections of pre-tax benefits such as an FSA during the year. Otherwise, your election cannot be changed until the next annual Benefits Open Enrollment period.