# FLEXIBLE BENEFIT ELECTION FORM
## Wesleyan University
**January 1 to December 31, 2024**


*Keep your card from year to year!*

The Flexible Benefit Plan allows you to make your contribution toward your benefits with pre-tax dollars. These dollars are not subject to FICA, federal or state income taxes. The plans covered by this agreement are listed in the **Summary Plan Description** and include the Flexible Spending Accounts listed below.

| | | **Annual** | **Per Pay** |
|---|---|---|---|
| **Medical Care Flexible Spending Account**<br>For reimbursement of eligible medical care expenses for you, your IRS-defined spouse and qualified dependents | | | |
| Maximum: | $3,200 per plan year | $ | $ |
| **Note:** Your participation in this Medical FSA could disqualify you/your spouse from establishing, making and/or receiving contributions to a Health Savings Account as defined in Code Section 223. | | | |

| | | | |
|---|---|---|---|
| **Dependent Care Flexible Spending Account**<br>For reimbursement of eligible work-related child care or elder care expenses | | | |
| Maximum: | $5,000 per plan year *Single or Married, filing jointly*<br>$2,500 per plan year *Married, filing separately* | $ | $ |

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above. I understand this agreement will remain in effect until the end of the plan year unless one of the following events occurs: A change in legal marital status due to marriage, divorce, legal separation, annulment, or my IRS defined spouse's death; a change in the number of my qualified dependents due to birth, adoption, placement for adoption, or death; a change in employment status for me, my spouse or qualified dependent that affects benefits eligibility, such as termination or commencement of employment, a reduction or increase in hours worked, a strike or lockout, commencement of, or return from an unpaid leave of absence, or a change in worksite; an event that causes my qualified dependent to satisfy or cease to satisfy status as a dependent; a change in my, my spouse's or my dependent's residence; special enrollment rights; certain judgments, decrees and orders; entitlement to Medicare or Medicaid; certain changes in cost; and certain changes in coverage. Each of these events is defined in the **Summary Plan Description** and any request for change will be governed by the terms outlined in the Summary Plan Description and the underlying group health plans (when applicable). I further understand that in the event the cost of a non-flexible spending account benefit I have selected changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

**I certify that my GDI Debit Card will be used only for payment of qualifying medical expenses that have been incurred by me or my qualified dependents. I understand that the card is for use on the Medical FSA only.** I acknowledge that I have received information on qualifying medical expenses. Further, I agree to save all invoices and receipts for any expense I pay with the Card and, upon request, to submit these documents for review by the Plan.

Employee Name (please print)

Employee Date of Hire | Employee Date of Birth | Email address

Address | City | State | Zip

Employee Signature | Date

**Human Resources/Payroll please complete**: Effective Date: _____ First P/R Date: _____ Payroll Cycle: W B S M

*IRS regulations prohibit sole proprietors, partners, LLC members and greater than 2% subchapter S Corp. owners from participating in a flexible benefit plan.*