



2017 FLEXIBLE BENEFIT ELECTION FORM

Employee Name – Please Print

Preferred Phone #

PSU ID #

HEALTH CARE REIMBURSEMENT ACCOUNT

Out-of-pocket medical, dental, and vision expense for faculty-staff and dependents. For guidance on eligible and ineligible expenses, please refer to the Flexible Benefits information online. **Minimum contribution is \$10 per month and the maximum contribution is \$2,500 per year.**

- I elect to participate and my authorized contribution from my PRETAX salary per **PAY PERIOD** is *(do not enter the amount of the annual contribution)*

\$ _____.

- I elect **NOT** to participate

DEPENDENT CARE REIMBURSEMENT ACCOUNT

Work-related daycare, nursery school, elder care, etc. NOT for dependents medical expenses. For guidance on eligible and ineligible expenses, please refer to the Flexible Benefits information online. **Minimum contribution is \$10 per month and the maximum contribution is \$5,000 per family, per year.**

- I elect to participate and my authorized contribution from my PRETAX salary per **PAY PERIOD** is *(do not enter the amount of the annual contribution)*

\$ _____.

- I elect **NOT** to participate

CERTIFICATION/SIGNATURE

I have indicated my benefit elections for this calendar year in the appropriate sections. I understand that I may change my elections only during the Annual Election Period or in the event of a change in family status as defined in the FLEXIBLE BENEFITS information and as outlined in the section below.

I understand that:

- Reimbursement Account elections **do not renew automatically** each year
- Participation in any future year will require a new election to be completed during the appropriate election period
- Reimbursements may be made only for eligible expenses incurred during the Plan Year regardless of when payment was made
- Reimbursements are subject to IRS regulations
- If I do not apply for the reimbursement of the full amount of my contributions before the end of the Grace Period, I will forfeit the unused balance.

Signature

_____/_____
Date Signed

Return completed form to the office listed below:

CERTIFICATION OF CHANGE IN FAMILY STATUS

The Penn State Flexible Benefits Plan, in accordance with the Internal Revenue Code, requires your Flexible Benefit Elections to remain in force for the entire year unless you experience a change in family status. Those qualified changes are listed below. If you have experienced a change in family status and desire to change your level of participation, complete this certification below and make the appropriate deduction amount changes on the front of this form. This form must be signed, dated and received by Employee Benefits within 60 days of the event. **All changes must be on account of and consistent with the change in family status event.**

I am requesting a change in my Flexible Benefit Election for the Plan Year _____.

The date of the change in family status event that prompts this request is _____.

Check the appropriate event:

Your marriage

Birth or adoption of child(ren): _____
Name(s) of child(ren)

Death of spouse or a dependent

Name

Relationship

Your divorce (actual divorce, not separation)

Termination or commencement of spouse's employment
(valid only if health benefits provided by spouse's employer begin or end as a result of the change)

Change in your dependent care costs

From

To

CERTIFICATION AND SIGNATURE FOR CHANGE IN FAMILY STATUS

I acknowledge that if I am ending my participation in any reimbursement account, reimbursements will be limited to expenses incurred before the date of this form. If I am electing a reimbursement account in which I did not previously participate during this Plan Year, reimbursements will be limited to expenses incurred after the date of this form. I understand that the favorable tax treatment under the Penn State Flexible Benefit Plan is dependent upon the accuracy of my statements. I certify that the information, events and dates indicated are accurate and truthful.

Signature

_____/_____/_____
Date Signed

Return completed form to the office listed below:

Employee Benefits Division, James M. Elliott Building, University Park, PA 16802
Service Center: (814) 865-1473, Fax: (814) 865-6820
E-mail: benefits@psu.edu, Website: <http://ohr.psu.edu/benefits>