FOR EMPLOYER USE ONLY

Plan Year Ending	12/ 31 / 09
Effective Date	01/ 01 / 09

FLEXIBLE SPENDING PLAN ELECTION FORM

Employer**: OHIO NORTHERN UNIVERSITY**

Name: ________________________________ SS#: ____________________

Address: ____________________________ City: ____________ State: ____ Zip: ______

Email Address: ____

Date of Birth: ______/_____/______ Check One: ☐ Male ☐ Female
Month Day Year

Pay Cycle (Check One): ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Name of Beneficiary: ______________________________ Relationship: ____________

Address (If different): ______________________ City: ____________ State: ____ Zip: ______

Do you or any of your family members have any other medical or dental coverage? Yes ☐ No ☐

If YES, coverage is on: ☐ Myself ☐ Spouse ☐ Dependent Children

☐ **I elect to contribute $__________ per year to my Health Care Reimbursement Account**.
This amount will be set aside before taxes are calculated to reimburse me for qualified out-of-pocket health care expenses for myself and/or my qualified dependents.

☐ **I elect to contribute $__________ per year to my Dependent Care Reimbursement Account.**
(Maximum of $5,000/family or $2,500 if married, filing separately) This amount will be set aside before taxes are calculated to reimburse me for qualified dependent day care expenses.

☐ **I decline participation in Reimbursement Accounts.**

Special Features:

☐ I elect to participate in the **Automatic Reimbursement** feature so that any unpaid amounts on claims processed by EBMC will automatically be reimbursed from my Health Care Reimbursement Account. I certify that neither my dependents nor I have any other medical or dental coverage.

☐ I elect to have my reimbursements **directly deposited** into my checking or savings account. I have attached a deposit slip or voided check from the appropriate account.

☐ I elect to use the same account number as last year.

I understand that this election will be in effect for the entire plan year, unless I experience a “Change In Status” as defined by the IRS. I further understand that any amounts in my account not used for eligible expense incurred during the plan year will be forfeited at the end of the plan year based on current tax regulations. I agree that I will only submit claims for my qualified tax-dependents.

______________________________________ ____________________

Signature of Employee Date