Participation and Salary Reduction Agreement
University of Hartford Flexible Benefits Plan
Plan Year: January 1, 2009 through December 31, 2009

I. Participant Identification (please print or type)

Participant Name:______________________________ **Social Security Number:**____/____/____

Address: ____ **DOB:** ____/____/____

City:________________ **State:** ____ **Zip:**__________ **Email:**______________________

II. Agreement to Participate and Salary Reduction Agreement

Please check below for the benefits you are selecting and indicate the amount of salary reduction for each pay period for the Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account. Sign and date the form and return it to the Office of Human Resources Development, Financial and Administrative Services Building.

Please check your number of pay periods in the Plan Year: 12 [ ] 20 [ ] 26 [ ]

Flexible Spending Arrangements	Annual Election	Salary Reduction Per pay
[ ] Dependent Care FSA (not to exceed $5000.00 annually)	________.___	________.___
[ ] Health Care FSA (not to exceed $5000.00 annually)	________.___	________.___

I hereby authorize the University of Hartford to reduce my cash compensation as indicated above for each pay period during the plan year following the date of this agreement.

I understand that this election form cannot be revoked or changed during the plan year unless there is a change (qualifying event) in my family status which qualifies for a revocation or change (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, or termination of employment of spouse). I further understand that salary reductions must be reimbursed for qualified expenses incurred during the plan year and may not be carried over into future plan years.

If, at the end of the plan year, the total reduction in compensation exceeds my qualified expenses, I understand that the difference in amounts will default to the plan.

I have read and understand the rules regarding the use of my debit card for eligible health care FSA expenses. I certify that the card will only be used for eligible medical expenses at eligible providers. I further certify that the amount of eligible expenses is not reimbursable from any other source, nor will I attempt to be reimbursed from any other source. I will maintain documentation for all expenses and where required, provide applicable documentation upon request. If I cannot produce adequate documentation, I understand that I must repay the plan for such an expense. Failure to repay the plan will result in the moneys being withheld from my pay. If I terminate employment or participation in the plan, I will return the debit card to my employer.

My signature below indicates that I have read and understand this election form and the descriptive material(s) provided.

______________________________ ____________
Participant Signature Date

______________________________ ____________
Agreed and accepted by Date
University of Hartford Representative

(HRD Use Only): Effective Date: ____/____/____
1st Withholding: ____/____/____

Hirsch ____
Payroll ____
Er File ____
Audit File ____