UNIVERSITY OF HARTFORD

Participation and Salary Reduction Agreement

Flexible Spending Account FSA(s)

Plan Year: January 1, 2019 through December 31, 2019

I. Participant Information

Name (please print): _____

UH ID#: _____ **Email Address:** _____**@hartford.edu**

Address: _____

Street **City** **State** **Zip Code**

II. Agreement to Participate and Salary Reduction Agreement

Select the FSA account(s), per-pay contribution and annual election(s) for the Plan Year noted above.

Please check your number of pay periods in the Plan Year: 20 [ ] 24 [ ] 26 [ ]

Flexible Spending Account(s)	**Salary Reduction Per Pay**		**Number of Pay Periods**		**Annual Election**
[ ] Dependent Care FSA (not to exceed $5,000 annually)	_____	X	_____	=	_____
[ ] Health Care FSA (not to exceed $2,700 annually)	_____	X	_____	=	_____

III. Participation Acknowledgement

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 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. If, at the end of the plan year, the total reduction in compensation exceeds my qualified expenses, I understand that the difference in amounts in excess of $500 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 substantiation for all expenses and where required, provide applicable substantiation upon request. If I cannot produce adequate substantiation, I understand that I must repay the plan for such an expense. 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
University of Hartford Representative

Date

HRD USE ONLY

[ ] PDADEDN completed by: _____ Date: _____ Audit Completed by: _____

[ ] PayFlex Notification completed by: _____ Date: _____ Date: _____