UNIVERSITY OF MISSISSIPPI
Human Resources Department
PO Box 1848 – University, MS 38677
PH: (662) 915-7431 | FAX: (662) 915-5836
EMAIL: hrbenefits@olemiss.edu

THE UNIVERSITY of MISSISSIPPI | Human Resources

****2023 FSA EXTENDED OPEN ENROLLMENT ****

FLEXIBLE SPENDING ACCOUNT (FSA) Enrollment/Change Form

Employee Name:	Date of Hire: Employee ID#:
Mailing Address:	Employee Status: ☐ 9 -month ☐ 12 -month
City/State/Zip:	Marital Status:
Home Phone: Work Phone:	Email Address:
SSN: Date of Birth:	Gender: ☐ Male ☐ Female ☐ Undeclared
Is your spouse employed by the University of Mississippi?	☐ No ☐ Yes – Provide Name: _____

University employees are paid twice a month. Premium deductions for 12-month employees occur over 24 pay periods and for 9-month faculty members over 18 pay periods. Pay Mode: Semi-Monthly

Flexible Spending Accounts (FSA) -- Contributions are withheld 12-month / 9-month -- *Section 125 Cafeteria Plan*

☐ **Dependent Care Spending Account**
Annual Election per Family: $5,000 $_____

☐ **Unreimbursed Medical Spending Account**
Annual Election per Individual: $3,200 $_____

Prescription FlexCard: ☐ Yes ☐ No **You will receive (2) cards, at no charge. There is a $10.00 per card replacement fee if lost or stolen. The fee will be deducted from your eligible card balance.*

☐ **Waive/Cancel Participation** **To cancel participation in an existing plan, write "0" in the blank next to the respective plan type*

Direct Deposit Information: Name of Bank/Financial Institution: _____
Routing #: _____ Account #: _____ ☐ Checking ☐ Savings

FOR HUMAN RESOURCES ONLY

$_____ per pay period (DC) $_____ per pay period (MR) | Effective Date: _____

I acknowledge that I voluntarily and without coercion made elections/waivers as documented on this form. I understand my salary will be reduced by the amount(s) shown on this enrollment form for the eligible benefit options I have elected and since premiums are collected one month in advance, the University will collect premiums in arrears as an additional payroll deduction. If my salary reduction for the elected insurance benefit(s) increases or decreases while this agreement remains in effect, my salary will automatically be adjusted to reflect the change.

As a Cafeteria Plan benefit, my election will be irrevocable for the Plan Year except for modifications due to a qualifying event (divorce, marriage, death of spouse/dependent child, birth/adoption of a child, change of employment status of me or my spouse, cost of coverage/change, HIPAA special enrollment rights, or other event specified by the IRS) provided I complete enrollment paperwork to request the election change and submit to the Human Resources Department no later than 60 days after the date of the qualifying event. Prior to each Plan Year, I will be given the opportunity to change my benefit election. If I fail to complete and submit to the Human Resources Department a new election form within the allotted enrollment period, I understand my election will remain the same.

I understand my social security benefits may be reduced due to my participation in the Cafeteria Plan. My employer may reduce or cancel the amount of my salary reduction or otherwise modify this agreement to satisfy certain provisions of the Internal Revenue Code.

I understand my elected benefits will cease upon separation of employment, but I will be afforded an opportunity to continue coverage via COBRA for qualifying plans.

If I participate in dependent care, reimbursements cannot exceed the amount incurred during the Plan Year. If I participate in reimbursed medical, I may be reimbursed for qualifying out-of-pocket medical expenses. Claims must be filed with Southern Administrators and Benefit Consultants (SABC) no later than 60 days into the subsequent Plan Year. Any account balance over the $640 rollover processed after the 60-day grace period will be forfeited.

I understand that privacy statements are available via the University website at http://hr.olemiss.edu/benefits/. If I do not have internet access, I can request a paper copy from the Human Resources Department. As an employee, I acknowledge that I am the subscriber of coverage and that the Privacy Policy is also applicable to my spouse and/or my dependents. I also understand I will be reissued the Privacy Statement, as a material modification is made and every three years, via the University's email system.

This election and salary reduction agreement is subject to the terms of my employer's cafeteria plan document.

EMPLOYEE SIGNATURE _____ DATE SIGNED _____