

**◆◆ LSU HEALTH SCIENCES CENTER ◆◆**  
**Spending Account Election Form**  
**New Election / Name / Address Change / Status Change**

**1. Personal Information (Complete all information. Please print.)**

Employee Name: \_\_\_\_\_ Change:  Yes  No

Employee Address: \_\_\_\_\_ Change:  Yes  No

Employee Social Security Number: \_\_\_\_\_

Employee Birthday: \_\_\_\_\_ Hire Date: \_\_\_\_\_  
(New employees have 30 days to enroll)

**2. Dependent Care Spending Account**

- I choose to participate in a Dependent Care Spending Account Maximum - \$5,000 or \$2,500 if married and filing separately; Minimum - \$300. I agree to reduce my salary per pay period by an amount of : \$ \_\_\_\_\_ X 12 or X 24 pay periods
- I choose not to participate in a Dependent Care Spending Account.

**My total election for the Plan Year is \$ \_\_\_\_\_**

I understand that my election cannot be more than my annual salary or my spouse's (if married), whichever is less and that reimbursement from all employer plans CANNOT exceed \$5,000.

**3. Medical Savings Account**

- I choose to participate in a Medical Savings Account Maximum - \$3,000; Minimum - (none). I agree to reduce my salary per pay period by an amount of : \$ \_\_\_\_\_ X 12 or X 24 pay periods
- I choose not to participate in a Medical Savings Account.

**My total election for the Plan Year is \$ \_\_\_\_\_**

**4. Debit Card Election**

- I elect to receive a debit card with my flexible account(s). I understand that I will be assessed a one time fee of \$5.00 which will be deducted from my account.

**5. Signature**

By signing this form, I understand that:

- ◆ My elections for the year cannot be changed unless my family circumstances change.
- ◆ Any money remaining in my account at the end of the year will be forfeited.
- ◆ The deductions I have elected are made in accordance with the Plan Document and will be deducted in equal installments from my paychecks.
- ◆ I agree to pay an administrative fee for participating in this plan in the amount of \$3.30 per month for one FSA account or \$5.50 per month for two FSA accounts.
- ◆ These elections will remain in place until revoked or changed during the annual open enrollment period in April of each year, to be effective July 1, the beginning of the new plan year.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Plan Year beginning July 1, 2009**

Please return this form to the Human Resource Management Department