RESET

UNIVERSITY OF TENNESSEE FLEXIBLE BENEFITS PLAN

FSA ELECTION & COMPENSATION REDUCTION AGREEMENT — 2024 PLAN YEAR

University of Tennessee • Payroll, Benefits and Retirement • Flexible Benefits Administration
505 Summer Place - UT Tower 907 • Knoxville, TN 37902 • 865.974.5251 • utinsurance@tennessee.edu

Complete this form only if you wish to participate in the Medical, Limited Purpose or Dependent Care Reimbursement Account

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	**PER NO** (FRM EMP ID CARD)

HOME ADDRESS	CITY	STATE	ZIP CODE

DEPARTMENT NAME		DATE OF EMPLOYMENT	**EFF DATE FOR DEDUCTION**

WORK PHONE	PAYROLL FREQUENCY (PAYCHECKS PER YEAR)	ENROLLMENT STATUS
	☐ BI-WEEKLY ☐ MONTHLY	☐ New Hire ☐ Change

REIMBURSEMENT ACCOUNT ENROLLMENT (new elections must be filed each year)

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact the Payroll office for additional information at 865-974-5251 or utinsurance@tennessee.edu

If you are enrolled in the HealthSavings CDHP, you are not eligible to contribute to the Medical Expense Account; however, you may contribute to the Limited Purpose Account (for vision and/or dental expenses only).

In Box #1, indicate the reduction amount per pay period. In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year. Consult your payroll office if you are unsure of how many checks you will receive. In Box #3, indicate the total dollar amount you elect to contribute for the plan year.

MEDICAL EXPENSE ACCOUNT

Maximum allowable annual contribution for 2024 is $3,050 (Minimum contribution for the year is $120)

Box #1 Reduction per regular paycheck		$
Box #2 Number of reg. paychecks (remaining)	X	
Box #3 Total plan year dollar amount	=	$

LIMITED PURPOSE ACCOUNT

ONLY TO BE USED WITH AN EXISTING HSA ACCOUNT AND THE CDHP HEALTH OPTION
Maximum allowable annual contribution is $3,050 (Minimum contribution for the year is $120)

Box #1 Reduction per regular paycheck		$
Box #2 Number of reg. paychecks (remaining)	X	
Box #3 Total plan year dollar amount	=	$

DEPENDENT CARE ACCOUNT

Tax Filing Status (please check one)

☐ Married, filing separately (maximum $2,500)
☐ Married, filing jointly (maximum $5,000)
☐ Head of household (maximum $5,000)

Box #1 Reduction per regular paycheck		$
Box #2 Number of reg. paychecks (remaining)	X	
Box #3 Total plan year dollar amount	=	$

AUTHORIZATION

- I understand this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I hereby authorize my employer to reduce my gross salary before federal, state and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file an approved family status change.
- I understand that any amount remaining in my Dependent Care account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year. I also understand that any funds in excess of $610 remaining in either the Medical Expense Account or Limited Purpose Account at the end of the year will be forfeited. Funds of $610 or less will carry over into the following year if I re-enroll.
- I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forego my right to participate during the upcoming plan year.

EMPLOYEE SIGNATURE	DATE

Return this application to The University of Tennessee Benefits Office, 505 Summer Place - UT Tower 907, Knoxville, TN 37902
For questions regarding enrollment or a family status change, please contact the Benefits Office 865.974.5251

(rev 9/22)