

REIMBURSEMENT ACCOUNTS ELECTION AND COMPENSATION REDUCTION AGREEMENT CALENDAR YEAR 2010

The University of Tennessee
Flexible Benefits Plan
Phone: (865) 974-5251
<http://flexiblebenefits.tennessee.edu>

Monthly _____
Biweekly _____

Name: Last	First	MI	Employee ID
Responsible Account	Employment Date	Effective Date	Office Phone

Indicate the benefits you wish to pay through tax-free salary reduction by checking the appropriate boxes and entering the necessary information below. Calculate contributions carefully as funds not used within 2 ½ months of the following year are forfeited.

	Reimbursement Account	Annual Amount	Pay Period Amount
<input type="checkbox"/>	Medical Expense - Indicate the amount you wish to contribute. Medical expenses are limited to 20% of base annual salary or \$5,000, whichever is less. Annual amount divided by 12 if paid monthly, by 24 if paid biweekly. If for less than a year, divide annual amount by remaining pay cycles in the calendar year.	\$ _____	\$ _____
<input type="checkbox"/>	Dependent Care Expense – Indicate the amount you wish to contribute. Dependent care expenses are limited to \$2,500 for a married person filing a Separate tax return or \$5,000 for a family or single parent household. Annual amount divided by 12 if paid monthly, by 24 if paid biweekly. If for less than a year, divide annual amount by remaining pay cycles in the calendar year. NOTE: <u>Dependent Listing form must accompany this form at enrollment.</u>	\$ _____	\$ _____

IMPORTANT

- I understand that this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I understand that my State Group Medical Premiums will be paid automatically through tax-free salary reduction unless waived.
- 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 any Reimbursement Account that is not used during the plan year, or within 2 ½ months of the following year, will be forfeited since it cannot be carried to the next plan year.
- I understand and agree that the University will not incur any liability resulting from either my participation in or 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 forgo my right to participate during the upcoming plan year.

Employee Signature	Date