UNIVERSITY OF HARTFORD

Participation and Salary Reduction Agreement

Flexible Spending Account FSA(s) **Plan Year: January 1, 2022 through December 31, 2022**

I. Participant Information

Employee Name (please print): _____

SSN#: _____ **Email Address:** _____ **@hartford.edu**

Home 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.

Flexible Spending Account(s)

☐ I elect to maximize my contribution(s) based on 2022 IRS guidelines.

☐ Dependent Care FSA
☐ Health Care FSA

	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 $2,750 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 $550 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.

_____ _____
Employee Signature Date

_____ _____
Human Resources Development Representative Date

HRD USE ONLY

☐ PDADEDN (initials): _____ Date: _____
☐ Combined limit field updated
☐ Updated PayFlex file

Audit Completed by: _____
Date: _____