

HR Office Use Only:
Effective Date _____

**UNIVERSITY OF NEW MEXICO
FLEXIBLE SPENDING ACCOUNTS
MEDICAL REIMBURSEMENT ENROLLMENT FORM**

SOCIAL SECURITY NUMBER _____ STATUS Single Married Domestic Partner

LAST NAME _____ FIRST _____

Street address including apartment number if applicable _____

City, State, Zip _____

Home telephone _____

Department name _____

Work telephone _____

I will be submitting medical reimbursement claims for myself and/or the following legal dependents:

MEDICAL REIMBURSEMENT ACCOUNT AUTHORIZATION FORM

I would like to contribute \$ _____ biweekly/monthly for a yearly total of \$ _____. **DO NOT INCLUDE AMOUNTS OF ANY OF YOUR HEALTH, DENTAL AND/OR VISION PREMIUMS AS PART OF THIS FIGURE.** (Maximum year amount \$5,000). I understand that this choice cannot be changed during the plan year, unless I have a qualifying change of family status.

I hereby authorize the necessary withholding from my pay to make the contribution indicated. I further understand that if I fail to use all my contributions to reimburse myself for eligible expenses incurred during the plan year, I will forfeit the remaining amount, as required by the Internal Revenue Code Section 125.

Signature

Date

Complete this form and deliver to the Human Resources Service Center, 1730 Lomas NE, Albuquerque, New Mexico 87131-3186 **NO LATER THAN THE OPEN ENROLLMENT DEADLINE OR WITHIN 60 DAYS OF ELIGIBILITY.** If you are enrolling during the Plan Year, be sure your election reflects your contributions from the date the enrollment form is signed through December 31.