BENEFITS & EMPLOYEE WELLNESS

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2025-2026 FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

Plan Year: July 1, 2025 – June 30, 2026

You must submit your FSA Enrollment Form to Benefits & Employee Wellness via (Choose one)

Secure Document Upload at https://hr.unm.edu/secure-upload
Fax to 505-277-2278

Section I: Complete Employee Information

Last Name _____ First Name _____ Middle Initial _____

UNM Banner ID _____ Date of Birth _____

_____
Street Address including Apartment Number (if applicable)

_____ _____
City, State Zip Telephone Number

Section II: Complete Election Choices (effective July 1, 2025 – June 30, 2026)

HEALTH CARE FSA* (Maximum Election Amount is $3,300)

Monthly Employees:

Select your Election Amount* for remaining months of FSA plan year $ _____
Next, Divide Election Amount by number of months remaining in plan year $ _____
(This is the amount that will be taken from each of your paychecks)

Bi-weekly Employees:

Select your Election Amount* for remaining months of FSA plan year $_____
Next, Divide Election Amount by (number of months remaining in plan year x 2) $_____
(This is the amount that will be taken from each of your paychecks)

*(Do **not** include any of your Insurance premiums as part of this figure)

DEPENDENT CARE FSA** (Maximum Election Amount is $5,000)

Monthly Employees:

Select your Election Amount** for remaining months of FSA plan year $ _____
Next, Divide Election Amount by number of months remaining in plan year $ _____
(*This is the amount that will be taken from each of your paychecks)*

Bi-weekly Employees:

Select your Election Amount* for remaining months of FSA plan year $ _____
Next, Divide Election Amount by (number of months remaining in plan year x 2) $ _____
(This is the amount that will be taken from each of your paychecks).

(This Account does **not reimburse for dependent medical, dental or vision expenses)

WEX Inc. will issue two Debit Cards for FSA expenses. Note: not all providers are set up to accept FSA Debit Cards.

SECTION III: Sign and Date the Form

I hereby authorize the necessary withholding from my pay to make the contribution as indicated. I further understand that if I fail to use all my contributions for eligible expenses incurred during the Plan Year, I will forfeit access to the remaining funds in my account that are in excess of the Carryover/Grace Period, as required by the Internal Revenue Code Section 125. **I understand that this choice cannot be changed during the Plan Year, unless I experience a Qualifying Life Event.**

IF UPLOADING ELECTRONICALLY TO HR'S SECURE DOCUMENT UPLOAD SITE, MY PRINTED NAME BELOW SERVES AS MY SIGNATURE.
SIGNATURE IS REQUIRED IF PROVIDING PAPER FORM VIA FAX .

_____ _____
Signature Date