BENEFITS

Benefits Office Use Only: EB___ EM____ or RP___

Date Downloaded _____ Date received _____

Date entered _____ Entered by _____

2020-2021 FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT/CHANGE FORM

Plan Year July 1, 2020 – June 30, 2021

You must submit your Enrollment/Change Form to HR Benefits via
Secure Document Upload at https://hr.unm.edu/upload or

- **Fax to 505-277-2278**

Late enrollments or changes will NOT be accepted.

Section I: Complete Employee Information

Social Security Number _____ UNM Banner ID _____ Date of Birth _____

Last Name _____ First Name _____ Middle Initial _____

_____
Street Address including Apartment Number (if applicable)

_____ _____
City, State Zip Telephone Number

Section II: Complete Election Choices

HEALTH CARE FSA (Maximum Plan Year Election Amount is $2,750)

- Select your total 2020-2021 Election Amount* $ _____
- Starting with the first of next month, how many months remain in the Plan Year? _____
- Divide your total Election Amount by the number of pay periods remaining in the 2020-2021 Plan Year $_____

Bi-weekly Employees: Divide this number by 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 Plan Year Election Amount is $5,000)

Monthly Employees:

- Select your total 2020-2021 Election Amount* $ _____
- Starting with the first of next month, how many months remain in the Plan Year? _____
- Divide your total Election Amount by the number of pay periods remaining in the 2020-2021 Plan Year $_____

Bi-weekly Employees: Divide this number by 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)

☐ **I would like a McGriff Benefit Access Visa® Debit Card for FSA expenses. Two cards will be issued.**

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 or MAIL.

_____ _____
Signature Date