Samford University
2017 Election Form
Medical Spending Account Agreement

Employee Name:_____ SUID:_____

Home Address: _____

Samford Email Address: _____

Department:_____ Work Number:_____

Beneficiary: _____
** The beneficiary should be the person you wish to have access to your account should you pass away during the plan year.*

I hereby elect to participate in the Medical Spending Account Flex Plan for the plan year 2017:

Medical Spending Account: I want my taxable compensation to be reduced for qualifying health care expenses. The **total annual amount** I want to contribute is:

$_____($2600 max.)

Note: The annual amount of compensation you contribute into your flexible spending account(s) will be converted to a per payperiod amount for monthly paid employees. Contributions for bi-weekly employees will also be converted to a per payperiod basis, with the exception of the 2 months per year in which there are 3 pay periods. During those 2 months contributions will be deducted from the first two paychecks in the month.

By signing my name below, I agree or understand that:

- This election is irrevocable during the plan year except as indicated below.
- The offering organization or any of its subsidiaries may change or suspend the reduction of compensation if the Internal Revenue Service, through legislation or restrictive regulation, limits or prohibits salary reduction as currently permitted under Section 125 of the Internal Revenue Code, or if such a change is necessary to avoid adverse tax consequences under the Internal Revenue Code.
- This election is subject to the terms of the Flexible Benefits Plan of my employer.
- My employer is released from all present and future rights or claims to any sums reduced from my salary and used for reimbursement of eligible expenses in accordance with the provisions of the Flexible Benefits Plan.
- Reduced amounts of taxable compensation not used to pay for eligible benefits during the plan year will be forfeited.
- I may change my elections only in the event of a change in my family status, as defined in the Plan, e.g., birth or adoption of a child, or death of a spouse or dependent, disability, divorce, marriage, termination or commencement of employment, changing from full-time to part-time or vice versa by me or my spouse, etc.
- I must request all changes within 30 days of a change in family status. The new election form must be received by Human Resources within the 30-day time frame.

Further, I accept responsibility for the proper treatment of benefits paid under this plan with respect to all individual income tax reporting.

_____ _____
Employee Signature **Date**