



PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: **Eastern Michigan University**

Participant First Name: _____ Last Name: _____

Social Security #: [] [] [] - [] [] [] - [] [] [] [] Date of Birth: _____ / _____ / _____

Address: _____

City, State, Zip: _____ Phone Number: _____

E-mail Address: _____ (Notification of direct deposit payment is sent via e-mail)

Pay Period: Weekly Semi-Monthly (twice a month) Bi-Weekly (every other week) Monthly

MEDICAL REIMBURSEMENT ACCOUNT

I elect to participate (not to exceed employer limit of \$5000)

\$ _____ per pay x _____ (# of pays in plan year) = \$ _____ Annually (do not round)

Is this Medical Reimbursement Account a Limited Purpose Account (see page 6)

I elect NOT to participate

DEPENDENT CARE ACCOUNT

I elect to participate (not to exceed \$5000 or \$2500 if married filing separately)

\$ _____ per pay x _____ (# of pays in plan year) = \$ _____ Annually (do not round)

I elect NOT to participate

EMPLOYER USE

Please complete for mid-year enrollments

Date of first deduction: _____ Eligibility date: _____

DIRECT DEPOSIT (not all employers allow direct deposit as a reimbursement option)

I elect to participate (there is no need to complete this section, unless you are changing accounts)
checking account OR savings account

CHECK EXAMPLE

Ⓜ 23456789 Ⓜ 0000123456 Ⓜ 1234

routing number account number check number

Financial Institution (name of bank): _____

Routing Number (always 9 digits): [] [] [] [] [] [] [] [] [] Account Number: _____

If you would prefer, you can attach a voided check.

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____

TEAR ALONG THIS LINE