Section 125 Flexible Spending Account (FSA)

Reimbursement Plan Election Form: **January 2027 – December 2027**
for Eligible Out-of-Pocket Health Care & Dependent Care Expenses

HR Use ONLY	
☐ FDP	
☐ FMP	$
☐ Salaried	Total Election Amount
☐ Hourly	

Section A. EMPLOYEE INFORMATION

Name: _____ **PLU ID#** _____ **Effective Date:** _____

Address: _____ **Work Phone:** _____ **Department:** _____

Here are the benefits available under the plan: Unreimbursed Health Care and Dependent Care Expenses. Please indicate your benefits choice by noting the amount you elect to contribute in the boxes below. Your selections will remain in effect for the plan year, or until a subsequent election form is filed, in accordance with the plan.

Section B. HEALTH CARE REIMBURSEMENT

☐ **Monthly amount you want to contribute from your salary:**

For current eligible employees: the maximum amount contribution for 2027 is $3,500.

For newly eligible employees: If you enroll in the Health Care Reimbursement, your monthly deductions are based on your elected annual contributions divided by the number of months remaining in the calendar year.

Total Monthly Contribution: _____

Section C: DEPENDENT CARE REIMBURSEMENT

☐ **Monthly amount you want to contribute from your salary:**

For current eligible employees: the maximum amount contribution for 2027 is $7,500 (up to $3,750 for married individuals filing a separate tax return).

For newly eligible employees: If you enroll in the Dependent Care Reimbursement, your monthly deductions are based on your elected annual contributions divided by the number of months remaining in the calendar year.

Total Monthly Contribution: _____

Section D. SIGNATURE

1) I hereby authorize and direct payroll to deduct my salary in the amount necessary to pay for the coverages shown above in accordance with the **Pacific Lutheran University's Reimbursement Plan**. Such deductions, considered elective contributions under the plan, shall commence with my paycheck dated:
(Month) (Year) for the period which is the later of the upcoming Plan Year, which runs from January 1, through December 31 or the month following my paycheck noted above, through December 31.

2) I also understand that the purpose of this program is to allow employees and retirees to select their qualified benefits within the guidelines of the Internal Revenue Code, Section 125. I have read the following:
"My selection will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as defined by the IRS and includes things like marriage, divorce, death of a spouse or child, birth or adoption of a child, and change of employee and/or spouse's employment status. Financial hardship does not qualify as a change in family status."

3) I understand the terms and conditions of participation in the plan, as outlined to me via the enrollment benefits guidebook available on the Human Resources website.

Signature: _____ **Date:** _____