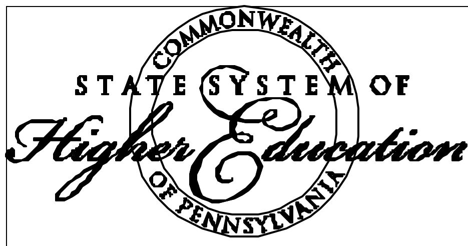

PA State System of Higher Education | Benefits, Hughes Hall | 2986 North Second Street |Harrisburg, PA 17110-1201 717-720-4160 | www.passhe.edu

ENROLLMENT FORM FOR MEDICAL REIMBURSEMENT ACCOUNT

BEFORE COMPLETING THIS FORM, READ INFORM ATION ON REVERSE SIDE. PLEASE PRINT OR TYPE.

NAME (Last, First, MI)	SOCIAL SECURITY /EMPLOYEE ID #	UNIVERSITY

Daytime Telephone Number	E-Mail Address

❑ Open Enrollment ❑ New Employee	Plan Effective Date	Annual Deduction* $	Biweekly Deduction (Annual Deduction ¸ No. of Pay Periods) $

*$3,000 maximum January 1 to December 31. This maximum is prorated for a new employee based on date of hire.

Calculate only the amount needed to cover your medical expenses for you and your dependents for the calendar year for which you are enrolling. **According to Federal Regulation, any money remaining in the account after all timely claims for the year have been submitted must be forfeited.**

I authorize the Pennsylvania State System of Higher Education to reduce my gross biweekly pay by the biweekly deduction specified above.

I understand that in order to receive reimbursement for my medical expenses they must meet the following criteria:

- Incurred for services or supplies by me or my eligible dependents,
- Incurred on or after the effective date of my spending account,
- Have not been reimbursed in any other way,
- Internal Revenue Service approved health care expenses.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my medical reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

I agree and understand that any misstatement or falsification of material facts will result in my removal from the Medical Reimbursement Account and may further cause an IRS and/or State audit with possible additional tax, interest, and penalties.

Employee Signature	Date	Benefits Counselor Name	Clock Number

I understand that:

(1) I may enroll, disenroll, or change my deductions only during the annual open enrollment or within 30 days of a Change in Status as defined in the plan document.
(2) A Change in Status must be reported within 30 days of the event to qualify for a change in deductions.
(3) My gross biweekly pay will be reduced every pay period by the amount I specify on this Enrollment Form.
(4) My medical reimbursement account must be used only for IRS approved health care expenses incurred during the calendar year.
(5) Under IRS regulation, any amount remaining in my medical reimbursement account after all timely claims have been submitted must be forfeited.
(6) As a result of reducing my taxable wages for the calendar year, my future Social Security benefit may be lower.

Examples of Change in Status:

- **Birth or Adoption of a Child**
- **Placement for Adoption**
- **Gain Custody of Dependent**
- **Lose Custody of Dependent**
- **Death of Dependent**
- **Marriage**
- **Annulment**
- **Legal Separation**
- **Divorce**
- **Death of Spouse**
- **Change in Residence of Self, Spouse, or Dependent that affects Eligibility for Coverage**
- **Change in Employment Status of Self, Spouse, or Dependent (includes start or end of employment, strike or lockout, beginning or end of a leave without pay, and change in worksite)**