BALDWIN WALLACE UNIVERSITY
FLEXIBLE BENEFITS ENROLLMENT FORM
FOR THE PLAN YEAR JANUARY 1, 2013 – DECEMBER 31, 2013

Name: _____
(Please Type or Print)

Social Security Number: _____ Department: _____

☐ New Enrollment ☐ Change in Family Status

Medical Reimbursement Account

Per Pay, 2013 please deduct $ _____
(24 pays for Bi-weekly, 12 pays for Monthly employees)

Total for Plan Year 2013* is $ _____

* Total for Medical Plan Year 2013 may not exceed $2,500.00

Dependent Care Reimbursement Account

Per Pay, 2013 please deduct $ _____
(24 pays for Bi-weekly, 12 pays for Monthly employees)

Total for Plan Year 2013* is $ _____

* Total for Dependent Care Plan Year 2013 may not exceed $5,000.00

By signing below, I understand that I am authorizing Baldwin Wallace University to reduce my compensation by the amount I have selected for the Medical and/or Dependent Care Reimbursement Account. I also understand that I may not change my selection for 2013, unless I have a change in family status, which would allow a new selection for 2013. I further understand that any amount remaining in the Medical and/or Dependent Care Reimbursement Account at the end of the Plan Year (December 31) that is not eligible for reimbursement will be forfeited.

_____ _____
Signature of Employee Date

Medical and Dependent Claim Forms available at; **www.bw.edu/resources/hr/forms** and in Human Resources.