THE UNIVERSITY OF IOWA

THE UNIVERSITY OF IOWA SALARY REDUCTION AGREEMENT FOR SPENDING ACCOUNTS

_____ _____

Printed Name (Last, First, Middle Initial) Employee ID # or University ID #

Effective on and after the first day of _____ (month), _____ (year), I instruct The University of Iowa to reduce my taxable salary by the amount stated below for my contribution to the Spending Account program designated:

Dependent Care $_____ (Monthly Amount)
Health Care $_____ (Monthly Amount)

Changes outside of the annual open enrollment period may only be made for qualifying events such as those listed in #3 below. Changes permitted are limited to those consistent with the reason for the change. Indicate the specific event related to this request.

Event: _____ Date of Event _____

Individuals Affected by Event _____

I understand and agree to the following provisions:

1. That there are limitations on the maximum amount I can place in a Spending Account, including:
   a) Dependent Care:
      1. The maximum amount is $2,500 annually (or $208.33 monthly) if I will be filing my Federal Income tax return as "Married Filing Separately", or that the maximum amount is $5,000 (or $416.66 monthly) if I use any other tax filing status.
      2. If I am married and my spouse is employed, the maximum amount that can be allocated may not exceed the earned income of the lowest paid spouse.
   b) Health Care:
      1. The maximum amount is $2,550 annually.
2. That any money placed into my Spending Account and not used for eligible expenses incurred during the calendar year covered by this Agreement will revert to the University, and that I will have no claim to those funds.
3. This Agreement is irrevocable and may not be modified during the calendar year unless there is a “qualifying event” such as: marriage; divorce; death of spouse or dependent; birth/adoption; approved unpaid leave of absence from the University; spouse, partner or dependent gains or loses a job or changes residence, work schedules or work sites that affect benefit eligibility; change of daycare provider or cost. Changes must be made within 30 days of the date of this event (60 days due to birth/adoption).
4. That this Agreement shall continue from year-to-year so long as employment continues, and that the agreement is irrevocable except that I may alter or cancel this agreement during the month of December, to be effective for the following calendar year.
5. The University of Iowa requests this information for the purpose of enrolling you in the Spending Account program. Individuals outside of the University employed by the companies who supply and administer the University's benefits will have access to this information. No other persons outside of the University are routinely provided this information. Responses to items marked "options" are optional; responses to all other items are required. If you fail to provide the required information, the University may deny the respected benefit affected or complete the information to the best of its ability.

I further understand that this agreement is not only subject to all of the provisions set forth above, but that it will also be subject to any changes in those terms or additional limitations mandated by Federal law after the execution of the agreement.

_____ _____

Signature Date

RETURN THIS FORM TO THE UNIVERSITY BENEFITS OFFICE,
120 UNIVERSITY SERVICES BUILDING, IOWA CITY, IA 52242
FAX: (319) 335-2776