



Changing Benefits Elections For Current Employees

This material is not for new enrollments. New benefits eligible employees should call the benefit office to schedule a benefits enrollment orientation.

Norman Campus - Office of Human Resources
905 Asp Ave., NEL 242, Norman, OK, 73019 - (405) 325-2963.

OKC Campus - Office of Human Resources
P.O. Box 26901, SCB Rm. 122 - OKC, OK 73126 - (405) 271-2188.

Tulsa Campus - Office of Human Resources
4502 E. 41st. Street, Suite 1C114 - Tulsa, OK 74135 - (918) 660-3192.

This packet includes all the forms needed to change an employee's current benefits elections. In order to change benefits elections outside of the annual enrollment period the employee must have:

1) Experienced an Applicable Qualifying Event, as defined by the Internal Revenue Service (IRS). Changes based on financial reasons alone are not allowed under the current IRS regulations.

and

2) The request for a change of benefits must be made within **31 days** of the Applicable Qualifying Event.

Within the context of changing benefits, "Applicable" refers to a change that is directly related to the individual experiencing the qualifying event. "Qualifying Events" include:

- √ A birth or an adoption.
- √ Marriage, divorce or legal separation.
- √ A death.
- √ Child loses eligibility because of age or marriage.
- √ Employee's spouse gains or loses coverage through employment.
- √ Significant change in the financial terms of health benefits provided through a spouse's employer or another carrier.

Except for coverage of a newborn, all other changes in coverage begin the first day of the month following the qualifying event. Coverage for the newborn is effective on the child's date of birth. The premiums for newborn coverage cannot be pro-rated and must be paid for the entire birth month.

This packet included the following forms:

1) **Benefits Change Form** . All eight sections, both sides of this form must be completed. **NOTE:** Section 7 of this form (IRS Section 125 Qualifying Event Checklist) eliminates the need to provide the benefits office with any supporting documentation. However, you may be required to present proof of your qualifying event if you are audited by the IRS.

2) **Insurance Enrollment Form**. Complete this two page form **ONLY** if the "Add Employee Coverage" option is selected in Section 1 of the Benefits Change form.

3) **(FSA) Flexible Spending Account Enrollment Form**. Complete this one page form **ONLY** if you wish to open or change a "Health Care Reimbursement Account" or a "Dependent Care Reimbursement Account". This option is found in Section 3 of the Benefits Change form.



Benefits Change Form 2009 - Complete all the relevant sections and return the original signed copy to the Office of Human Resources. Some changes may require completion of additional documents. These will be forwarded to you upon receipt of this form. **NOTE:** Incomplete information can delay the processing of this form. This is a two page form. Both pages must be completed.

1 <input checked="" type="checkbox"/> Check the change requested	
<input type="checkbox"/> Employee name change - Enter new name in Section 2. Previous name:	<input type="checkbox"/> Add employee coverage Must complete an OU Insurance Enrollment Form.
<input type="checkbox"/> Address / Phone change - Enter changes in Section 2	<input type="checkbox"/> Terminate dependent child(ren) coverage
<input type="checkbox"/> Add dependent spouse	<input type="checkbox"/> Terminate all coverage
<input type="checkbox"/> Add dependent child(ren)	<input type="checkbox"/> Terminate dependent spouse's coverage

2 General Information			
First Name:	Last Name:	MI:	EMPL ID:
Street Address:			
City:	State:	Zip:	Phone:

3 <input checked="" type="checkbox"/> Check each benefit change.	Pre-tax	After- tax	<input checked="" type="checkbox"/> Check each deduction option.
<input type="checkbox"/> BlueChoice PPO	✓		
<input type="checkbox"/> BlueEdge HCA	✓		
<input type="checkbox"/> BlueLincs HMO	✓		Provider #:
<input type="checkbox"/> Community Care HMO (Tulsa Area Only)	✓		
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 50% <input type="checkbox"/> 66 2/3 % <input type="checkbox"/> High Option
<input type="checkbox"/> Long Term Care		✓	Additional application required to enroll
<input type="checkbox"/> Vision Standard	✓		
<input type="checkbox"/> Vision Premium	✓		
<input type="checkbox"/> Dental Basic	✓		
<input type="checkbox"/> Dental Alternate	✓		
<input type="checkbox"/> AD&D -Cannot pre-tax dependent coverage	<input type="checkbox"/>	<input type="checkbox"/>	Must include coverage amount on next line.
AD&D Coverage Employee \$	AD&D Coverage Spouse \$	Coverage Child \$	
<input type="checkbox"/> Life Insurance - Must include life insurance coverage option on next line.			
Employee Life Coverage Option <input type="checkbox"/> 1.5x <input type="checkbox"/> 3x <input type="checkbox"/> 4.5x <input type="checkbox"/> 6x	Spouse Life Coverage Option <input type="checkbox"/> .75x <input type="checkbox"/> 1.5x <input type="checkbox"/> 2.25x <input type="checkbox"/> 3x	Child Life Coverage Option <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	
<input type="checkbox"/> Health Care Reimbursement Account *	Total to be deducted for remaining calendar year: \$		
<input type="checkbox"/> Dependent Care Reimbursement Account *	Total to be deducted for remaining calendar year: \$		
*Requires the completion of a new Flexible Spending Account (FSA) Enrollment Form.			

4 Effective date of coverage change (MM/DD/YY):	
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5 Spouse Information			
Last Name:		First Name:	
MI:		MI:	
Gender:	SSN:	Date of Birth:	

6 Dependent 1 Information			
Last Name:		First Name:	
MI:		MI:	
Gender:	SSN:	Date of Birth:	

Dependent 2 Information			
Last Name:		First Name:	
MI:		MI:	
Gender:	SSN:	Date of Birth:	

Dependent 3 Information			
Last Name:		First Name:	
MI:		MI:	
Gender:	SSN:	Date of Birth:	


7 IRS Section 125 Qualifying Event Checklist

In order to make a change that affects your tax sheltered medical, dental, or vision premiums, you will need to indicate (Check) the qualifying event that is consistent with such a change. The same requirements apply to changes in your Flexible Spending Account for either your un-reimbursed medical account or dependent care account. All changes must be made within 30 days of the qualifying event.

Change in Legal Marital Status		Date of Change	Name of Individual
<input type="checkbox"/>	Marriage (excludes common-law)		
<input type="checkbox"/>	Divorce/Legal Separation		
<input type="checkbox"/>	Death of Spouse		
<input type="checkbox"/>	Annulment		
Change in Number of Dependents		Date of Change	Name of Individual
<input type="checkbox"/>	Birth		
<input type="checkbox"/>	Adoption/Placement for Adoption		
<input type="checkbox"/>	Death		
Gain/Loss of Other Coverage		Gain/Loss Date	Name of Individual (s)
Gain or Loss of other verifiable insurance coverage. Check all that apply: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
Change in Employment Status(that affects eligibility) of Employee/Spouse/Dependent		Effective Date	Name of Individual
<input type="checkbox"/>	Termination of Employment Name of other group insurance >		
<input type="checkbox"/>	Commencement of Employment Name of other group insurance >		
<input type="checkbox"/>	Strike or Lockout		
<input type="checkbox"/>	Leave of Absence (going on or returning from)		
<input type="checkbox"/>	Commencement of unpaid leave (LTD qualifies)		
<input type="checkbox"/>	Terminate/rehire within 30 days (reinstate original election)		
<input type="checkbox"/>	Terminate/rehire after 30 days (original or new election available)		
Change in Status Affecting Dependent Eligibility		Date of Change	Name of Dependent
<input type="checkbox"/>	Commencement of Student Status (age 19-25 & full-time student) Name of accredited school >		
<input type="checkbox"/>	Ineligible - (Check <input checked="" type="checkbox"/> which criteria applies): <input type="checkbox"/> Loss of student status (age 19-25 & full-time student), <input type="checkbox"/> Attained age 25 <input type="checkbox"/> Financially independent before age 19, <input type="checkbox"/> Marriage		
<input type="checkbox"/>	Ineligible due to age 13 (Dependent Day Care only)		
Change in Residence affecting HMO: Employee/Spouse/Dependent		Date of Change	Name of Individual
<input type="checkbox"/>	Explain:		
"Other" Employer Change for Spouse or former Spouse covering children, includes Spouse's Option Period		Date of Change	Name of Individual
<input type="checkbox"/>	Significant Coverage Reduction		
<input type="checkbox"/>	Significant Cost Increase		
<input type="checkbox"/>	Addition or Elimination of a Benefit		
Entitlement to Medicare or Medicaid		Date of Change	
<input type="checkbox"/>	Commencement allows cancellation/reduction of medical or flex acct		
<input type="checkbox"/>	Loss allows commencement/increase of medical or flex acct		
Other Qualifying Events			
<input type="checkbox"/>	Family Medical Leave Act: Re-elect benefits upon return to work		
<input type="checkbox"/>	Change of Custody, Judgment, Court Order or Decree requiring medical coverage, including Qualified Medical Child Support Orders (QMCSO): If employee has court order to cover a dependent child(ren), changes must be consistent with order.	Date of Order	Name of Dependent(s)

8 Employee's Signature and Date

Your signature confirms that all statements herein are true. Documentation that authenticates these statements could be required during an audit. Refer to Title 74 Oklahoma Statutes § 1323, Fraud – Penalties

Print your name here:	EMPL ID:
Signature here 	Date:

This completed original form must be returned to your local benefits office.

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Insurance Enrollment Form - 2009 Plan Year New Enrollees

Select one: Norman Campus Oklahoma City Campus Tulsa Campus

Complete all sections of this form and return this original signed document to your local Benefits Office: **Norman Campus** - Office of Human Resources - 905 Asp Ave., NEL 244, Norman, OK, 73019 - (405) 325-2961 **OKC Campus** - Office of Human Resources, SCB, Rm. 118 – P.O. Box 26901 OKC, OK 73126 - (405) 271-2188. **Tulsa Campus** - Office of Human Resources - 4502 E. 41st. Street, Suite 1C114 - Tulsa, OK, 74135 - (918) 660-3190.

1 Employee Information					
Last:		First:		Middle:	
Home address:					
City:		State:		Zip:	
SSN:	EMPL ID:	Date of Birth (MM/DD/YY):		Gender:	
Home phone:		Work phone:		Email address:	

2 Medical Insurance:				
<input type="checkbox"/> BlueChoice PPO	<input type="checkbox"/> BlueEdge HCA	<input type="checkbox"/> BlueLincs HMO	<input type="checkbox"/> Community Care HMO (Tulsa Area only)	<input type="checkbox"/> I Waive Medical Coverage (Proof of coverage required.)
Individuals Covered:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Children	<input type="checkbox"/> Employee and Family
Identification Number of Primary Care Physician (PCP) for Employee (For HMO applicants only):				
Spouse PCP # (For HMO applicants only):		Child(ren) PCP # (For HMO applicants only):		

3 Dental Insurance: University provides paid coverage for full-time benefits eligible employees under the Basic Plan Option.				
<input type="checkbox"/> Option One (Basic Plan)		<input type="checkbox"/> Option Two (Alternate Plan)		<input type="checkbox"/> I Waive Dental Coverage
Individuals Covered:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Family

4 Vision Insurance: This is university sponsored optional insurance coverage paid for by the employee.				
<input type="checkbox"/> Option One (Basic Plan)		<input type="checkbox"/> Option Two (Premium Plan)		
Coverage Options:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Family

5 Dependents - List all individuals to be covered by this enrollment.							
Coverage	Name	Relationship	Gender	Date of Birth	SSN	Full Time College Student ?	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> AD&D						<input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee: Last:	First:	SSN:
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6 Life Insurance - The university provides paid coverage for full-time employees at the 1.5 times salary level.

NOTE: If coverage selected is more than \$450,000, the additional coverage will NOT be in effect until a supplementary application is completed and approved. You may call the benefits office for a copy of the Life application, or one will be sent upon receipt of this form. See the benefits guide for details.

<input type="checkbox"/> Accept Life Coverage		<input type="checkbox"/> Waive Life Coverage	
Employee coverage options:	Spouse coverage options:	Child(ren) coverage options:	
<input type="checkbox"/> Basic Life 1.5x annual Salary	<input type="checkbox"/> .75x <input type="checkbox"/> 1.5x <input type="checkbox"/> 2.25x <input type="checkbox"/> 3x	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	
<input type="checkbox"/> Supplemental Life: <input type="checkbox"/> 1.5x <input type="checkbox"/> 3x <input type="checkbox"/> 4.5x	N/A	N/A	

7 AD&D Insurance: (NOTE: Employee coverage is pre-tax. Spouse and child(ren) coverage will be after-tax). University provides paid coverage for full-time employees at the \$20,000 level.

<input type="checkbox"/> Accept AD&D Coverage		<input type="checkbox"/> Waive AD&D Coverage	
Coverage amount for employee \$	Coverage amount for spouse \$	Coverage amount for child(ren) \$	

8 Beneficiary Information - Required for (L) Life Insurance and (A) AD&D Insurance. **NOTE:** Unless indicated on this form, the Employee will be designated as the Primary Beneficiary for all dependent coverage.

Policy	Beneficiary Name	Beneficiary SSN	Date requested	Relationship	Primary or Contingent ?	Initial here
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						
<input type="checkbox"/> L <input type="checkbox"/> A <input type="checkbox"/> Both						

9 Employee Long Term Disability Insurance: Pre-tax After-tax (select one). This is university sponsored optional insurance coverage paid for by the employee.

Coverage Options:	<input type="checkbox"/> Option 1 (66 2/3%)	<input type="checkbox"/> Option 2 (50%)	<input type="checkbox"/> Option 3 (Restricted, see benefits guide)
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10 Long-Term Care Insurance: This is university sponsored optional insurance coverage paid for by the employee. Must be paid with after-tax dollars. Note: Additional insurance application required to enroll in this insurance plan.

Coverage For:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Spouse Only	<input type="checkbox"/> Employee and Spouse
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11 For Employees With Children

Is another person, other than you or your spouse, legally responsible for your children? Yes No

12 Other Coverage - If you or your dependents are enrolling in university provided medical care, will you or your dependents also be enrolled in any other medical care coverage elsewhere? Yes No. If yes, please list all sources of coverage here.

Name	Insurance Company	Policy Number

Authorization - I represent the information contained on this enrollment form to be complete and accurate to the best of my knowledge. Furthermore, I authorize any health care professional or entity to provide the plan administrators (or their authorized designees) all the information needed to process the necessary insurance claims on my behalf.

Signature	Date:
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Flexible Spending Account (FSA) Enrollment Form 2009

To establish a Health Care Reimbursement Account or a Day Care (Dependent Care) Reimbursement Account, read, fill out and return this original form to your local campus benefits office.

Flexible Spending Accounts (health care reimbursement and day care reimbursement accounts) make it possible for employees to use pre-tax income to pay for qualified expenses. The money deposited in a reimbursement account is not considered taxable income and is therefore exempt from income taxes. It is important to take the time to understand the provisions of the plan before enrolling. Once a reimbursement account has been established, it cannot be changed during the plan year unless the employee has experienced an Applicable Qualifying Event (see the Benefits Enrollment Guide for details). Furthermore, **IRS regulations require that any money not spent by the end of the expense period will be forfeited to the employer.**


NOTE: Health Care and Dependent Care FSA plans have different expense periods. Health Care FSA expenses can be incurred through March 15 of the following year. In effect the Health Care FSA is a fourteen and one half month plan. The Dependent Care FSA expenses can be incurred through December 31 of the calendar year. The Dependent Care FSA is a true twelve month plan. Employees should plan to contribute what they will need for the entire expense period.


Reimbursement requests will be processed by PayFlex, a Blue Cross Blue Shield of Oklahoma partner. Under PayFlex's administration, you can use your PayFlex Debit Card to pay for healthcare claims directly with no upfront out-of-pocket expense. However, documentation, such as receipts, should be kept during the year. Dependent care claims, and certain health-related expenses that cannot be automatically processed will still require filing an ExpressClaim at www.mypayflex.com or a paper reimbursement request form. The minimum reimbursement amount is five dollars. These claims can be reimbursed directly to your bank account after completing a direct deposit authorization form or a check can be sent to your home address.



For more information about a health care or a day care reimbursement account, see the reverse side of this form.

Name:		Work Number:	
Your 6 digit EMP ID: (Not your SSN. This number is on your payroll statement)		Email:	
I am paid: <input type="checkbox"/> Monthly over 12 months <input type="checkbox"/> Monthly over 9 months <input type="checkbox"/> Hourly (paid bi-weekly)			

 Health Care Reimbursement Account here	Enter the total dollar amount that is to be put into this account for the <u>Expense Period</u> \$
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 Day Care Reimbursement Account here (Dependent Care Reimbursement Account)	Enter the total dollar amount that is to be put into this account for the <u>Expense Period</u> \$
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Enrollment Note: The total amount deducted per pay period will be equally divided by the remaining pay periods. A monthly employee starting a PayFlex FSA at the same time will have his total contribution deducted over the 12 monthly day periods. **Norman Campus Hourly Payroll Only:** Payroll deduction for an FSA will be deducted from all twenty-six weekly payrolls.

READ BEFORE SIGNING: I understand and approve the enrollment as indicated above. I hereby authorize the University of Oklahoma to deduct from my earnings the amount of contributions indicated above. I understand that I will not pay federal or state tax on my elected pre-tax contributions because my salary will be reduced by these contributions. I understand that these choices are in effect through December 31 of the following calendar year, unless I make changes to my account allowable because of an Applicable Qualifying Event. Furthermore, my contributions will not be renewed for the next plan year until I complete and return another FSA form during the annual enrollment period.



Employee's signature		Date
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This completed original form must be returned to your local benefits office.

Health Care Reimbursement Account Facts

Accounting Issues - Expenses must be incurred by March 15, 2009. Participants have **until April 15, 2009** to submit all claims. There is a \$5,000 maximum contribution limit per plan period. The requested amount will be paid, as long as it does not exceed total annual contribution, less prior payments.

Reimbursements cannot be requested for expenses that have already been paid or will be paid by another source, such as an insurance company or another employer. Medical expenses that have been reimbursed through a health care reimbursement account **cannot** be credited against an income tax return. Participants no longer employed by the university may continue to submit reimbursement requests for eligible expenses incurred during the plan year prior to their date of termination.

Non-Eligible Expenses - Some examples of **non-eligible** expenses are: Cosmetic Surgery (unless to correct a deformity) ▪ Custodial Care in an Institution ▪ Funeral and Burial Expenses ▪ Health Club Fees ▪ Vitamins (unless by prescription) ▪ Insurance Premiums.

Eligible Reimbursable Expenses - Some examples of eligible expenses are:

- | | | |
|-----------------------|--------------------|----------------------|
| ▪ Artificial Teeth | ▪ Flu Shots | ▪ Prescription Drugs |
| ▪ Birth Control Pills | ▪ Hearing Aides | ▪ Psychiatric Care |
| ▪ Chiropractor | ▪ Insulin | ▪ Equipment Rental |
| ▪ Contact Lenses | ▪ Immunizations | ▪ Surgeon Fees |
| ▪ Co-payments | ▪ Lab Fees You Pay | ▪ Vision Care |
| ▪ Crutches | ▪ Physical Therapy | ▪ Well Baby Care |
| ▪ Deductibles | ▪ Physician Fees | ▪ Wheelchairs |
| ▪ Eyeglasses | ▪ Physical Exams | ▪ X-rays |

(A complete listing can be obtained from IRS publication 502)

New IRS Guidelines On Over-The- Counter Drugs – Some over-the-counter drugs can now be paid for with pre-tax dollars when using your health care flexible spending account. Examples of eligible medications are those used to alleviate injuries or sicknesses including: antacids, allergy medicines, cold medicines, and pain relievers. Over-the-counter medications that do not qualify under the new guidelines are those products that are used to maintain the general health of the employee, spouse or dependent. Examples include dietary supplements (e.g., vitamins) without a physician's prescription.

Day Care Reimbursement Account Facts

Eligibility - Employees that need custodial care for an eligible dependent so that the employee and spouse can work (or go to school full-time) qualify for a dependent care reimbursement account. If married, the spouse must work or be a full-time student. The annual amount submitted for reimbursement cannot exceed the amount earned by the lower paid spouse. For a full-time student, an income of \$200 per month for one dependent, \$400 for two or more is assumed.

Legitimate Expenses - Expenses must be for the care of a dependent that is 12 years old or younger and the employee must be entitled to a deduction for this dependent under IRS Code Section 151(e) or expenses for care must be for a spouse or dependent who is physically or mentally incapable of caring for himself or herself. Expenses for services needed to run the home by a housekeeper or maid are covered if they are partly for the well being and protection of the dependent. Expenses for food, clothing, education or entertainment for the dependent are not covered.

Payment For Services - Payment for services cannot be made to a person who is claimed as a dependent or to a child if the child is under age 19. The provider can be a relative who is not a dependent, even if the provider lives in the employee's home. If the services are provided for a disabled spouse or dependent outside the employee's home, the disabled spouse or dependent must spend at least eight hours each day in the employee's home. A provider who cares for dependents who are under age 13 and who cares for more than six individuals must comply with all state and local laws at the provider's location.

Types of Day Care Providers - Eligible types of day care providers are: Licensed day care centers ▪ Private preschool programs ▪ Home based licensed day cares ▪ Public or private before school and after school programs ▪ Private sitter in your home or theirs ▪ Public or private summer day camps ▪ Nursery schools. In order to claim expenses as a tax credit, the social security number or federal tax number of the provider must be submitted. Church sponsored day care centers are exempt from this requirement. Dependent care expenses must satisfy eligible criteria for a dependent care reimbursement account as outlined in Section 129 of the IRS code. Kindergarten is not an eligible expense.

Accounting Issues - There is a \$5,000 maximum contribution limit per plan year. Working couples can contribute a combined total of \$5,000 to this account. Deductions cannot exceed the earned gross income of a lower paid spouse, unless the spouse is a full-time student or is disabled. Expenses must be incurred within the current plan year. Reimbursements cannot exceed the amount that is in the account when the request is made. Participants have 30 days after the end of the expense period to submit all claims.