

UNIVERSITY OF DUBUQUE
FLEXIBLE SPENDING PLAN ELECTION FORM
2010 Plan Year (January 1 through December 31)

Section I - Employee Information

Employee-Last Name	First Name	Initial	Date of Birth	Social Security Number
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Street Address	City	State	Zip Code
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Type of Election: Annual Election New Hire Family Status change * see below

Explanation for change in Family Status _____

Effective date of this election (date of first paycheck with flexible spending reduction) _____

Pay Period: Monthly Bi-weekly

Section II - Flexible Spending Agreement

I hereby elect to have my salary reduced and a corresponding amount credited to my account in the Plan. Any previous election and compensation reduction agreement under the Flexible Spending Account relating to the same benefits is hereby revoked. I have read and understand the Summary Plan Description.

I agree to have my salary wages reduced as follows:

- I authorize to have my premium contribution(s) for Medical and Dental Health (if any) withheld prior to taxes as provided in Section 125.
- I authorize that my monthly/bi-weekly earnings be reduced in the amount of \$_____ for other **medical/dental expenses**, for a yearly contribution of \$_____. These would be expenses incurred which the health plan does not cover (i.e., deductibles, copayments, etc.). I understand I will only need to complete the attached claim form (attaching my bill, receipt or EOB) to receive reimbursement for any items not processed through the University of Dubuque Health Plan, or if I am covered under more than one health plan.
- I authorize that my monthly/bi-weekly earnings be reduced in the amount of \$_____ for **dependent care expenses, (daycare)** for a yearly contribution of \$_____. I understand I will need to submit a claim form to receive reimbursement.

I agree to notify the Company if I have reason to believe that any medical care expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand for any liability it may incur for failure to withhold federal and state income tax or Social Security tax from any reimbursement I receive on any non-qualifying expenses.

*****Automatic Rollover Payment Authorization*****

- I understand that this document is also a claim form for expenses processed through the University of Dubuque Health Plan and that any eligible amount unpaid will be rolled over the Flexible Spending Plan for reimbursement from my account.
- By checking this box, I verify that expenses automatically submitted to the Flexible Spending Plan during the year are actual expenses for which I am liable and that these expenses are not eligible for reimbursement/payment under any other source. I agree to notify the Company immediately if I have reason to believe that any expense automatically rolled over does not qualify for reimbursement under the Flexible Spending Plan.

Employee's Signature	Date	Accepted by University of Dubuque	Date
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Section III - Declining Flexible Spending Coverage

I hereby waive participation in the University of Dubuque Flexible Spending Account Plan for 2010. I understand I will not be able to elect participation until the new plan year begins.

Employee's Signature	Date	Accepted by University of Dubuque	Date
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*Please return your election to the Human Resources Department by December 31, 2009.