SAINT LOUIS UNIVERSITY
DEPENDENT CARE PLAN

2018 ENROLLMENT FORM

Maximum Annual Enrollment: $5,000

Name_____ Banner ID _____SSN _____
(Last) (First) (MI)

Home Address_____
(Street) (City) (State) (Zip)

Date of Birth_____ Gender: ☐ Male ☐ Female Date of Hire_____

Pay Site: ☐ Monthly ☐ Biweekly Work Phone_____ Home Phone_____

I hereby elect to receive dependent care reimbursement(s) under the Saint Louis University Dependent Care Plan for this Plan Year, beginning on January 1, 2018, my date of hire, or date of qualifying event, and ending December 31, 2018. I agree to reduce my compensation for such period by:

$ _____
(Total enrollment for the remainder of the current calendar year)

I have received, read and understand the **Summary Plan Description** and I realize:

1. The total amount that I elect to contribute will be withheld from all remaining pay periods, beginning with January 1, 2018, my date of hire, or date of qualifying event, and ending December 31, 2018.

2. I am making a binding election for salary reduction for my eligible Plan Year that can only be changed if there is a qualifying change in family or employment status.

3. Reimbursement will be available only for dependent care expenses qualifying under Section 213 of the Internal Revenue Code.

4. This election form terminates on December 31, 2018, which is the last day of the Plan Year. Participation in any subsequent Plan Year requires a new election to be completed during the annual Open Enrollment period for the year involved.

5. Any unused funds at the end of the Plan Year will be forfeited.

6. I will have 90 days following the end of the Plan Year, or March 31, 2019, to submit claims for eligible expenses that were incurred during the 2018 Plan Year.

Signature_____ Date_____

FOR BENEFITS USE ONLY

MN / BW $_____ per pay period Banner _____ PHICHEK _____

CYC _____ CYC File _____