Hope College Flexible Benefit Arrangement  
Plan Period: July 1, 2015 to June 30, 2016

Employee Name: ________________________________________     Hope ID #: _____________________

The Hope College Flexible Benefit Plan, worksheet for calculating flex estimates, and a list of eligible flex expenses are available at www.hope.edu/admin/hr/benefits/flex.html

DO NOT include premiums for health, dental or vision in your calculations.

I elect to participate in the employer sponsored Flex Medical Plan for benefit year 2015-16. I verify that I (and/or my spouse if applicable) will not be participating in any High Deductible Health Plan (HDHP) (including the College’s ORANGE Plan) or a Health Savings Account (HSA) during benefit year 2015-16

Medical Reimbursement Account ($2,550 maximum)
Annual Election for July 1, 2015-June 30, 2016 $___________ / _____* = $ ___________ per paycheck

*Flex contributions are withheld from pay twice a month throughout the benefit year. To calculate per paycheck amount, determine # of months left in benefit year (July – June) and multiply by 2 OR leave blank and this will be calculated for you by the Payroll Office.

I elect to participate in the employer sponsored Flex Child /Dependent Care Plan for benefit year 2015-16.

Child / Dependent Care Reimbursement Account ($5,000 maximum)
Annual Election for July 1, 2015-June 30, 2016 $___________ / _____* = $ ___________ per paycheck

*Flex contributions are withheld from pay twice a month throughout the benefit year. To calculate per paycheck amount, determine # of months left in benefit year (July – June) and multiply by 2 OR leave blank and this will be calculated for you by the Payroll Office.

Employee Signature: _____________________________________________  Date: ____/____/____