PLAN YEAR:
July 2025 - June 2026

Flexible Spending Medical, Dependent Care and/or Commuter and Transit Account Enrollment Form

Blue Cross Blue Shield of Rhode Island

Please Send Completed Form To:

Human Resources
One Old Ferry Road, Bristol, RI 02809
Email: human_resources@rwu.edu
Phone: 401-254-3028 Fax: 401-254-3370

Start here..

Employee Information:

Please Check Your
Employer Name: ☐ **Roger Williams University** ☐ **School of Law** Effective Date: 07/01/2025

First Name: Last Name:

Street Address: City: State: Zip:

Email Address: Phone #:

Date of Birth: EMPLOYEE NUMBER

For Each Benefit in Which You Wish to Enroll, Please Enter the Yearly Amount in the "Annual Contribution" Field(s) Below

Medical Reimbursement Account:
The 2025 IRS Maximum Annual Contribution for the year is **$3,300**

Annual Contribution: ☐ # of Pay Periods: 26
Per Pay Period: $ 0.00 First Payroll Date: 7/11/25

Dependent Care Reimbursement Account:
The 2025 IRS Maximum Annual Contribution for the year is **$5,000**

A letter from your provider is required

Annual Contribution: ☐ # of Pay Periods: 26
Per Pay Period: $ 0.00 First Payroll Date: 7/11/25

Commuter Reimbursement Account:
The 2025 IRS Maximum Annual Contribution for the year is **$3,900**

For each benefit

PARKING Annual Contribution: ☐ # of Pay Periods: 26
Per Pay Period: $ 0.00 First Payroll Date: 7/11/25

TRANSIT Annual Contribution: ☐ # of Pay Periods: 26
Per Pay Period: $ 0.00 First Payroll Date: 7/11/25

Dependent(s) Information *(if applicable)*:

Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No

** Please list additional dependents on back side of this enrollment form*

I Understand That:

(1) My employer will be deducting the allocations stated above from pay check for the purposes of funding my Flexible Spending Account plan(s).

(2) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for each new plan year.

(3) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status, marriage, divorce, death of spouse or child, birth or adoption of child, termination or commencement of employment of a spouse, or such other qualifying events allowed by the Internal Revenue Code that will permit a change or revocation of an election.

(4) London Health Administrators may reduce, cancel, or otherwise modify this agreement in the event they believe it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

(5)This agreement is subject to the terms of the Company's Flexible Spending Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

(6) By signing this form, I agree to the terms and procedures listed herein.

Employee Signature: _____ **Date:** _____

Plan Administrator: London Health Administrators