

**Old Dominion University Research Foundation Cafeteria Plan  
Dependent Care Reimbursement Account Election Form  
Plan Year 7/1/2023 through 6/30/2024**

Employee Name Printed _____ UIN _____
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I hereby elect the following option under the Old Dominion University Research Foundation Cafeteria Plan:

**DEPENDENT CARE**

       **YES**, I elect to participate in the Dependent Care Reimbursement Account for the Plan Year 7/1/2023 through 6/30/2024.

My election is in the **total annual amount of \$** \_\_\_\_\_, which is \$ \_\_\_\_\_ per pay period. I understand that this election is subject to the Plan minimum of \$120.00 annually and the Plan maximum of \$5,000.00 (or in the case of a married individual filing a separate return, \$2,500.00 annually.)

I understand that I cannot change or revoke this compensation redirection agreement at any time during the Plan Year unless I have a Change in Status, including marriage, divorce, death of a spouse or child, birth or adoption of a child, commencement or termination of spouse's or dependent's employment, switching from full-time to part-time or part-time to full-time employment by me or my spouse or dependent, taking unpaid leave of absence by me or my spouse or taking or returning from leave under the Family Medical Leave Act, a change in residence or place of work by me, my spouse or dependent, an event that causes my Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, student status, or similar circumstance) or a revocation or modification of benefits to include significant cost increases or decreases, coverage curtailment, addition or elimination of a benefit option.

**An election to participate will automatically terminate at the end of each Plan Year unless a new Election Form is completed and filed with the Plan Administrator during the annual Open Enrollment for the next Plan Year.**

I understand if the required contributions for the elected benefits are increased or decreased while this Agreement remains in effect, any pay redirection will automatically be adjusted to reflect that increase or decrease. If at the end of the Plan Year the total of my declared election exceeds the amount of my substantiated expenses for the Dependent Care Reimbursement Account, I recognize that the difference in the amounts will be forfeited by me. This Agreement is subject to the terms of the Old Dominion University Research Foundation Cafeteria Plan, as may be amended from time to time, and revokes any prior election and Salary Reduction Agreement relating to the Dependent Care Reimbursement plan.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date