EXHIBIT C

2008 Flexible Benefits Program

Enrollment/Change Form

☐ **New employee**
☐ **Open Enrollment**
☐ **Change**

Select one of the following if requesting a change:

- ❑ Legal marital status
- ❑ Number of dependents
- ❑ Employment Status (Termination or commencement of employment by employee, spouse or dependent)
- ❑ Other: _____
- ❑ Dependent satisfies or ceases to satisfy requirement for unmarried dependents.
- ❑ Change in work hours or work location (employee or spouse)

Please complete entire form for new employees or open enrollment. If making a change, indicate only employee name, social security number and items to be changed and sign the form. Return completed form to your employer.

Employee Information:

Name_____ Employee ID #_____SS# _____

Address_____ City_____State_____Zip_____

Date of Birth_____ Sex: Male ☐ Female ☐ Home Phone_____ Work Phone_____

Date of Hire_____ Current Job Title_____

Employment Status: Full time ☐ Part Time ☐ On Leave ☐ Other _____

Benefit Elections for Expenses Incurred Between January 1, 2008 and December 31, 2008

Spending Account Elections: I request the following amounts be deducted from my pay with pre-tax dollars:

	$ Per Pay Period	# of Pay Periods	Total $ for Plan Year	
Health Care Spending Account	$_____. _____	X _____	= $_____ Above $2,000 requires County approval	26 pay periods (or remaining pay periods from effective date)
Dependent Day Care Spending Account	$_____. _____	X _____	= $_____ $5,000 Maximum	If you are married and you and your spouse file a separate tax return, IRS regulations limit you to a $2,500 annual election to the Dependent Day Care Spending Account.

Eligible Premiums: I also request the following eligible contributions be deducted from my pay with pre-tax dollars

Disability Insurance Premium: (Non - SDI) □ Yes □ No

Note: By choosing to deduct your disability premiums pretax, should you receive disability benefits, those dollars will be taxable income.

Supplemental Life Insurance Premium: □ Yes □ No (**Unit's 19, 22, 30 and 36 ONLY**)

Agreement for Spending Accounts, the amount(s) I have elected will be taken from my pay in equal installments. I understand that if I fail to submit eligible claims for the entire amount elected, I forfeit any remaining balance. The election(s) will continue throughout the Plan Year or until I notify the company in writing of a qualifying Status Change. For Dependent Day Care Spending Account claims, I understand that I must submit the caregiver's tax identification number with each claim to obtain reimbursement for claims.

Signature _____ Date _____

Beneficiary _____ Relationship _____

Beneficiary Address _____ Phone _____

Debit Card Agreement

I agree to the following requirements in using the debit card for flexible benefit expenses:

1. The card will only be used to pay for eligible expenses incurred during the plan year for me, my spouse, and my dependents.
2. The expenses have not been and will not be reimbursed by insurance or another plan.
3. I should acquire and keep documentation/receipts for expenses paid for by the debit card and that I will submit copies of the documentation to the administrator, if requested.
4. My employer and Total Benefit Services, Inc. are not responsible for any adverse tax effects of improper expenditures.
5. If for some reason an improper payment has been made to me with the debit card, I am responsible for repaying the plan for the expense or providing other receipts for new eligible expenses to substitute for any improper or unsubstantiated expenses.
6. If repayment or other arrangements are not made within 15 days of notification of an improper payment, the card may be disabled.
7. If I do not repay the plan or make other arrangements, my employer can withhold the amount of the improper payment from my pay or other compensation to the extent consistent with applicable law.
8. If the card is found to be consistently misused, the card will be deactivated.

This debit card is automatically cancelled when an employee terminates employment.
Eligible expenses not paid by the debit card can be submitted for reimbursement. A completed Reimbursement Request form with receipts can be mailed or faxed to Total Benefit Services, Inc.

If you would like a debit card for your spouse please print their name and Social Security Number:

Spouse Name _____ Spouse Social Security #_____

Employee Signature _____ E-Mail _____

Authorization for Direct Deposit (for spending accounts only)

By signing below I authorize Total Benefit Services, Inc. to deposit expense reimbursements for my qualified health care/dependent day care expenses directly to my bank account indicated on the attached voided check. (Please attach voided check; deposit slips not accepted).

Signature _____

Employer's use only

Effective date of change: _____ First payroll deduction date: _____ [ ] Termination

Plan Administrator's signature: _____ Date:_____