2011 Flexible Benefits Program – Enrollment / Change Form

☐ **New Employee**
☐ **Open Enrollment**

☐ **Change – Qualifying Event** (Check box below)

- ❑ 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 requirements of coverage (age, student status, etc).
- ❑ Change in work hours or work location (employee or spouse)

Check appropriate box above and complete both pages of this form. If making a change due to a "qualifying event", indicate reason and attach supporting documentation (must be submitted within 30 days of qualifying event). Return completed form to Employee Benefits.

Employee Information:

Name _____ Employee ID Number _____

Address_____ City_____State_____Zip_____

Date of Birth_____ Male ☐ Female ☐ Home Phone_____ Work Phone_____

Date of Hire_____ Current Job Title_____

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

Flexible benefit elections are for expenses incurred **between January 1, 2011 and December 31, 2011**. In addition, the Flexible Spending Program allows a **grace period** for expenses incurred from **January 1, 2012 through March 15, 2012** if you have monies remaining in your flexible spending account on December 31, 2011.

CLAIMS MUST BE SENT TO TOTAL BENEFIT SERVICES BY MAY 15, 2012 OR MONIES WILL BE FORFEITED.

Spending Account Elections

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

	$ Per Pay Period	# Pay Periods	Total $ for Plan Year
Health Care Spending Account	$_____._____ X	_____ =	$_____ Above $2,000 requires County approval
Dependent Day Care Spending Account	$_____._____ X	_____ =	$_____ $5,000 Maximum

26 pay periods in a Plan Year (or remaining pay periods from effective date of change)

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 Elections

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

Cigna Disability Insurance Premium: ☐Yes ☐ No
(Applicable to enrolled unrepresented employees)

Note: If you elect "Yes" to have your premium pretax and you receive disability benefits, those dollars will be taxable income.

Supplemental Life Insurance Premium: ☐ Yes ☐ No (Applicable to **Units 19, 22, 30 and 36**)

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 to Total Benefit Services for the entire amount elected by May 15, 2012, I will forfeit any remaining and unused 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 _____

Employee Name _____

Beneficiary Information

(In the event of the participant's death, the assigned beneficiary may continue to submit claims for qualified expenses through the remainder of the plan year until the funds are exhausted. These may be for previously unclaimed qualified expenses incurred by the participant and his/her dependents or new qualified expenses incurred by the dependents.)

Beneficiary Name _____ Relationship _____

Beneficiary Address _____ Phone _____

Debit Card Agreement

(Note: It is not necessary to complete this section if you currently have a debit card.)

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 unless you are eligible to elect COBRA (contact Employee Benefits for details). 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. Please provide the e-mail address you would like Total Benefit Services to use to send you important information about your account.

Employee Signature _____ Date _____ E-mail _____

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

Spouse/Dep. Name _____ Spouse/Dep. Social Security _____

Authorization for Direct Deposit

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.
Note: If you currently have direct deposit for Plan Year 2010 and your bank information remains the same, you do not need to complete this section for Plan Year 2011. If your bank information has changed, please attach a voided check.

If you no longer wish to have direct deposit, you must check the box below to have your direct deposit removed.

I wish to cancel my direct deposit. ☐

Please attach voided check; deposit slips are not accepted.

Signature _____ Date _____

Employer's use only

Effective date of change: _____ First payroll deduction date: _____ ☐ Termination

Plan Administrator's signature: _____ Date: _____