



Saint Mary's College

FSA Enrollment Form

| EMPLOYEE INFORMATION | | | | BENEFIT ADMINISTRATOR SECTION | |
|---------------------------------|----------------|---|---------------|--|------------------------|
| LAST NAME | | FIRST NAME | MI | PLAN YEAR 1/1/2012 - 12/31/2012 | GROUP # 0198 |
| EMPLOYEE SOCIAL SECURITY NUMBER | | SEX <input type="checkbox"/> M <input type="checkbox"/> F | DATE OF BIRTH | EFFECTIVE DATE | DIVISION # |
| HOME ADDRESS | | | EMAIL ADDRESS | DATE OF HIRE | |
| CITY | | STATE | ZIP CODE | PAY CYCLE | |
| HOME TELEPHONE | WORK TELEPHONE | I GIVE THE FSA TEAM PERMISSION TO RELEASE INFORMATION ABOUT MY FSA TO MY SPOUSE. <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> MONTHLY - 12 PAYS <input type="checkbox"/> MONTHLY - 10 PAYS <input type="checkbox"/> BIWEEKLY - 26 PAYS <input type="checkbox"/> BIWEEKLY - 24 PAYS <input type="checkbox"/> BIWEEKLY - 22 PAYS <input type="checkbox"/> BIWEEKLY - 18 PAYS <input type="checkbox"/> OTHER: _____ | |

Please check all that apply:

HEALTH CARE ACCOUNT

I would like to contribute \$ _____ per pay period over _____ pays for an annual contribution of \$ _____ to my Healthcare Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by your employer is \$4,000 per plan year.

DEPENDENT CARE ACCOUNT

I would like to contribute \$ _____ per pay period over _____ pays for an annual contribution of \$ _____ to my Dependent Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by the IRS is \$5,000 per family or \$2,500 per individual (or spouse when married and filing separate tax returns)


ELIGIBLE DEPENDENTS:

| Dependent's Name (Last, First, MI) | Sex | Relationship | Birth Date | Social Security Number |
|------------------------------------|-----|--------------|------------|------------------------|
| | | Spouse | | |
| | | Child | | |
| | | Child | | |
| | | Child | | |

EMPLOYEE SIGNATURE REQUIRED

I understand that the above elections will remain in effect until the last day of the calendar year indicated on this Form. I understand that I may change my elections during the calendar year only if (1) I experience a "status change," as defined under the Plan and my change in elections is consistent with that "status change," or (2) I exercise a Special Enrollment Right as described in the Notice of Special Enrollment Periods that accompanies this Election Form. I also understand that if I do not submit a new Election Form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. I understand that the Employer may modify my benefit elections if appropriate to insure that the Plan complies with the requirements of the Plan and applicable law and that, subject to the requirements of applicable law, the Employer has the right to amend or terminate the Plan. I understand that if I fail to request Plan enrollment within 30 days after my (and/or my dependent's) other coverage ends, I will not be eligible to enroll myself or my dependent(s), as applicable, during the special enrollment period.

I authorize Saint Mary's College to reduce my earnings from my effective date by the amount(s) indicated above. Funds deposited into my Health Care and/or Dependent Care Flexible Spending Account(s) will be available to pay for eligible expenses during the plan year. The plan year begins January 1 and ends December 31. I will have until March 31 of the following year to submit expenses incurred during the plan year. I understand that Internal Revenue Service rules require that I forfeit unused account balances.

| | |
|---|------|
| EMPLOYEE SIGNATURE  | DATE |
|---|------|

Human Resources Use Only:

Date Received _____
 PM1 Deduction _____
 PD1 Deduction _____

Date Submitted _____
 Enrollment Confirmation _____
 Confirmation Info _____