

2008 FLEXIBLE SPENDING ACCOUNT ELECTION FORM

Please read carefully and complete section A and section B and/or section C of this form.

A. Personal Information

| | |
|--|------------------|
| Print Name (Last, First, Middle Initial): | Email Address |
| Banner ID # | Home Phone |
| Home Address (street, city, state, zip code) | |
| Department Name | Office Extension |

B. Health Care Reimbursement Account

I hereby elect to participate in the Health Care Reimbursement Account and authorize an **annual** contribution of \$_____. The minimum contribution is \$100 for the plan year. The maximum contribution is \$5,000 for the plan year.

C. Dependent Care Reimbursement Account

I hereby elect to participate in the Dependent Care Reimbursement Account and authorize an **annual** contribution of \$_____. The minimum contribution is \$100 for the plan year. The maximum contribution is \$5,000; \$2,500 if married and filing a separate tax return for the plan year (and subject to income limiting maximums established by the Internal Revenue Service).

Authorization and Acknowledgement:

1. The amount(s) indicated above will be deducted from my pay on a pre-tax basis in equal installments throughout the course of the plan year (January 1 - December 31).
2. I may not change or stop my contributions during the plan year unless my family or employment "change in status" event (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, unpaid leave of absence, etc.). Such a change in my election must be the result of, and consistent with, the event causing the election change, and must qualify under the terms and conditions of the plan.
3. I understand that I have a grace period of an additional 2 ½ months (thru March 15, 2009) after the end of the plan year to incur health care and/or dependent care expenses.
4. IRS rules require that any amount not used for covered expenses under my Health Care and/or Dependent Care Reimbursement Accounts cannot be returned to me. I understand that I have until May 31 of each year to submit claims incurred during the prior plan year.
5. I understand that I must submit a claim and appropriate documentation for out-of-pocket Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the FSA for eligible expenses incurred by myself or my eligible dependents. I certify that I will not submit claims for reimbursements under the FSA for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.
6. I have received and read all written materials provided to me describing the plans, and agree to the terms of participation set forth in the written materials.

Based on this election, I authorize the appropriate payroll adjustments accordingly.

Employee's Signature

Date