



*Health Care and Dependent Care
Flexible Spending Account Election Form
Plan Year January 01, 2009 thru December 31, 2009*

I, _____ (print name) authorize Dalton State College to reduce my regular monthly or bi-weekly paycheck in the amount designated below, and to deposit that amount in my **Health Care** and/or **Dependent Care Flexible Spending Account**. To reimburse me for the un-reimbursed Health Care and/or Dependent Care (childcare) expenses I may incur in the coming year, I understand that I can only change this election amount **once** each year, during the announced open enrollment period. However, in the event of one or more of the qualifying changes in family or employment status allowed by law, such as marriage/divorce, birth/adoption of a child, the death of a dependent, or change of employment status of my spouse the changes I elect must be consistent with the change in family or employment status incurred. Proper documentation for a change of status has to be provided. I acknowledge that I may request a copy of the **Health Care** and/or **Dependent Care Flexible Spending Account Plan Document** from the Office of Human Resources for details on how the plan is administered.

I understand that the claim(s) I may submit while actively employed during this plan year may total no more than the annualized amount I have designated below. I understand that if my employment terminates, my salary reduction will cease, however, I may continue to submit claims incurred during the current plan year until my funds are exhausted, or to the end of the current plan year, whichever comes first.

Flexible Spending Account Options	Per Pay Period Amount	Annual Amount
1. Health Care	\$	\$
2. Dependent Care *	\$	\$

- **Faculty elections reduced for 10 pay periods**
- **Monthly elections reduced for 12 pay periods**
- **Bi-Weekly elections reduced for 24 pay periods**

Employee Name (Printed)

Social Security Number

Employee Signature

Date

*NOTE: Present maximum annual deduction is \$5,000 if married; \$2,500 if married filing single.

PLEASE RETURN THE COMPLETED FORM TO THE PAYROLL OFFICE AND RETAIN A COPY.

(See Reverse)

MEDICAL CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available only for “**qualifying health care expenses**” as described in the **Summary Plan Description**.
- **I cannot change or revoke my Medical Care Reimbursement Account at any time during the plan year unless I experience a “change in status” event.** Such "change in status" events are defined in the **Summary Plan Description**.

DEPENDENT CARE ASSISTANCE

I understand that:

- Reimbursement will be available only for “**qualifying dependent care expenses**” as described in the **Summary Plan Description**.
- **I cannot change or revoke my Dependent Care Reimbursement Account at any time during the plan year unless I experience a “change in status” event.** Such change in status events are defined in the **Summary Plan Description**.

OTHER IMPORTANT TERMS AND CONDITIONS

I understand that:

- Before the first day of each plan year I will be offered the opportunity to review and/or change my benefits election for the new plan year. **If I do NOT fully complete and return a new election form prior to the first day of the new plan year,** I will be treated as having elected to **NOT** participate in reimbursement accounts effective for the new plan year.
- **I am solely responsible for notifying my employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.** I also agree to indemnify and reimburse my employer on demand for any liability it incurs for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive for a non-qualifying expense, up to the additional tax actually owed by me.
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he/she believes it is required in order to satisfy certain provisions of the Internal Revenue Code.
- **Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year.**
- My Social Security benefits may be slightly reduced as a result of my election.