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SOCIAL SECURITY #		HOME PHONE () ()		WORK PHONE (W/ EXTENSION IF APPLICABLE) () ()	
LAST NAME			FIRST NAME		MI
ADDRESS (STREET)			CITY		STATE ZIP
BIRTH DATE / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	DATE EMPLOYED / /	E-MAIL ADDRESS

ENROLLMENT STATUS: NEW ENROLLMENT REENROLLMENT CHANGE IN STATUS

INSTRUCTIONS

2 HOW TO ENROLL IN THE FLEXIBLE BENEFITS PLAN:
Indicate any benefits in which you want to participate by completing Section 3 below. Enter the corresponding annual election amount in the column to the right of the benefits you have chosen.
RETURN YOUR COMPLETED ENROLLMENT FORM TO Fringe Benefits Management Company (FBMC) at above address or fax toll free to 1-888-800-5217.

FLEXIBLE BENEFITS

3 Indicate all selections by entering the necessary information below. You must enter an amount under ANNUAL ELECTION AMOUNT to receive the corresponding benefit.

BENEFITS*

BENEFITS*	ANNUAL ELECTION AMOUNT
MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT - A calculator is available in the Reference Guide to help you calculate your annual contribution.	
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT - A calculator is available in the Reference Guide to help you calculate your annual contribution.	
TOTAL TAX-FREE SALARY DEDUCTION AMOUNT	

* For a Medical Flexible Spending Account (FSA) the minimum annual contribution is \$100 with a maximum annual contribution of \$2,500. For a Dependent Care Flexible Spending Account (FSA) the minimum annual contribution is \$250. The maximum annual contribution for a Dependent Care FSA is \$5,000; however, to determine if you qualify for the full amount, please see your Reference Guide for more information.

CHANGE IN FAMILY STATUS

4 DATE OF CHANGE IN FAMILY STATUS: _____ **DUE TO:** Marriage Divorce Birth or legal adoption of child
 Death of dependent Change in work status of spouse
 Significant change in health coverage due to spouse's employment
 Change in cost or coverage of Dependent Care

CHANGE - Please complete the following:

- I elect to change my Annual Salary Deduction Amount from \$ _____ to \$ _____ for the Unreimbursed Medical Spending Account due to a Change in Family Status.
- I elect to change my Annual Salary Deduction Amount from \$ _____ to \$ _____ for the Dependent Care Spending Account due to a Change in Family Status.

I hereby authorize my Employer to reduce my gross salary (before federal income and Social Security taxes are calculated) by the total annual election amount of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this Plan Year CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO MY EMPLOYER.

The total tax-free salary deduction amount specified above will continue in effect for the period of this plan year unless I discontinue or modify my Agreement through terminating employment or taking an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT MY EMPLOYER, UNION AND FRINGE BENEFITS MANAGEMENT COMPANY, THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN THE FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Employer or Employer's designee to serve as Agent to receive any funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs or for such other purpose as permitted under applicable state and federal law.

When enrolling in either or both FSAs, written notice of agreement with the following will be required: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

IMPORTANT: I understand that if I elect not to participate in salary reduction with respect to the FLEXIBLE BENEFITS PLAN benefits listed in Section 3 above, I hereby forego my rights to participate at this time.

EMPLOYEE SIGNATURE	DATE SIGNED
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FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES
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