Cuenta de Gastos Flexibles
BENEFICIO DE FORMULARIO DE INSCRIPCIÓN

Nombre del Empleador:____________________________ SS #______________________ División: ___________

Nombre del Empleado: ____ ______________________________________ Año del plan: __________

Street Address: ____

City: _______________________, State: _______, Zip Code: __________ E-mail: ___________________

<u>To elect amounts for the next plan year</u>, please enter an appropriate new ANNUAL deduction amount. DO NOT ROUND UP OR DOWN. With regard to Dependent Care, please be advised the amount not used for services INCURRED prior to the end of this plan year, will need to be reduced from the amount contributed to the next plan year. Maximum allowable amount per calendar year is $5,000.00 or $2,500.00 (if married and filing separately).

Benefit Description	Plan Year Election Amount (do not round up or down)	Number of payrolls during the plan year	MID-YEAR USE ONLY By Authorized Representative		
			Election Amount (no rounding)	Number of payrolls remaining	
FSA Medical Spending					Effective date is:
Annual Limit:					
FSA Dependent Care					First pay deduction will begin:
Annual Limit: $5,000					

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage shown above. Such reductions, considered as benefit elective contributions under the plan, will start with my first paycheck dated after the first of the plan year (for mid-year hires your effective date) and will continue for each pay period until this agreement is amended or terminated. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code.

Please note, any expenses incurred during the current plan year plus the Grace Period after plan year end must be submitted prior to the end of the Run Out period as defined in your Summary Plan Description. Any unused balances will be forfeited.

I understand if I terminate employment I may submit claims with a date of service incurred prior to the end of coverage date for a specified duration of time as stated in your Summary Plan Description.

If I have the mySourceCard debit card, I understand that it can only be used for eligible medical expenses. In addition, I certify that all claims paid with the mySourceCard have not been reimbursed and I will not seek reimbursement from any other plan covering health benefits.

I have read the Summary Plan Description with the Plan information Summary given to me by my Employer. This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status as listed on the Status Change Matrix I received with the Summary Plan Description.

To Authorize Participation: I hereby certify the above information to be correct and true and choose to participate in the plan.

Signature____ Date___________

Please return Enrollment Form to your employer's Human Resource Department no later then ________________________.

You must complete this form to participant in the new plan year. Thank you.