

FLEXIBLE SPENDING ACCOUNT ENROLLMENT 2012

NAME (Last, First, M.I.):	Social Security # or UMR ID #	Home Phone: ()
Address (Street, City, State, Zip):		Location: Community of Christ
Gender Female: <input type="checkbox"/> Male: <input type="checkbox"/>	Marital Status:	Date of Hire:
Reason for Submitting Form: New Enrollment: <input type="checkbox"/> Change in Family status: <input type="checkbox"/>		Effective Date:

Specific reason for change: _____

FLEXIBLE BENEFIT PLAN ELECTION:

MEDICAL AND/OR DENTAL REIMBURSEMENT PLAN:

I elect to allocate \$ _____ **per paycheck.**

To fund reimbursement of qualified health/dental care expenses NOT covered under my health or dental plan. The maximum contribution is \$3,000 per year.

Automatically reimburse me from my flex: Yes No

I wish to waive this election.

DEPENDENT DAY CARE ASSISTANCE PLAN:

Dependent care expenses (maximum is lesser of \$5,000, your spouse's total annual compensation, or 1/2 of your total annual compensation).

I elect to allocate \$ _____ per year.

(This amount will be divided by the appropriate number of pay periods.)

For the funding of reimbursement for qualified care expenses. The maximum contribution is \$5,000 per year.

I wish to waive this election.

AUTHORIZATION AND SIGNATURE:

I understand my enrollment in the Flexible Benefit Program is Voluntary. I understand that I cannot change my election for the plan year unless I have a change in family status, as defined by IRS code Section 125, which includes marriage, divorce, death of my spouse or child, adoption, termination or commencement of my spouse's employment, a switch from full-time to part-time (or part-time to full-time), employment by me or my spouse, or a significant change in the insurance coverage of my or my spouse under my spouse's employer's health care plan. I also understand that I forfeit any unused amounts at the end of each plan year.

Signature _____

Date _____