

<input type="checkbox"/>	NEW
<input type="checkbox"/>	CHANGE



FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM	PLEASE PRINT OR TYPE ALL ITEMS
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NAME OF EMPLOYER National Optical Astronomy Observatory		EMPLOYMENT DATE
NAME OF APPLICANT FIRST MI LAST		SOCIAL SECURITY NO.
ADDRESS: STREET CITY STATE ZIP		TELEPHONE
		OCCUPATION
SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	DATE OF BIRTH / /	MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>

FLEXIBLE SPENDING ACCOUNT ENROLLMENT INFORMATION

- ◆ I elect to participate in the Flexible Spending Account (FSA) as shown below. I agree to reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to our FSA. I understand that this reduces my wages for Social Security purposes.
- ◆ I understand that this election must be made annually, in advance of the plan year, and that I may not change this election unless I experience a qualifying event as defined by IRS regulations. Examples of qualifying events include but are not limited to Marriage, Divorce, change in employment status, and change in spouse employment status, dependent no longer eligible, birth or adoption of a child. Changes made due to qualified status changes must be made within 30 days of the qualifying event.
- ◆ Claims for reimbursement under the FSA must be for services received and paid during the plan year and must be submitted for reimbursement within three months of the end of the plan year or within three months of termination if my participation in the plan terminates prior to the end of the plan year.
- ◆ I understand that any contributions in the FSA not used for eligible expenses during my participation in the plan and during the plan year will be forfeited to the plan.

<p>Contribution Health Care Minimum \$100.00 Max: \$5,000.00</p> <p>Total Annual Election \$ _____ Per Pay Check \$ _____</p> <p>Open Enrollment Election for Plan Year <u>1/1/2010</u> through <u>12/31/2010</u></p>	<ul style="list-style-type: none"> • I certify that I do not have other insurance or FSA account, which covers eligible charges under the FSA.
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<p>Contribution Dependent Care Minimum \$100.00 Max: \$5,000.00 (or \$2,500 if married filing separately)</p> <p>Total Annual Election \$ _____ Per Pay Check \$ _____</p> <p>Open Enrollment Election for Plan Year <u>1/1/2010</u> through <u>12/31/2010</u></p>	<p>Dependent Care Spending Accounts general guidelines:</p> <ul style="list-style-type: none"> • Care is for your child or children under age 13, • A dependent who is unable to care for themselves and regularly spends 8 or more hours per day in your home may also qualify, • Services are for care of the dependent (not education), • Care provided by someone who is not your minor child, • If married you and your spouse must be employed • Annual amount cannot be more than ½ your income or more than your spouse's income, whichever is lower. <p><i>For some employees the Federal Child Care Tax Credit may be a better choice. Consult a tax advisor if you have questions</i></p>
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SIGNATURE OF EMPLOYEE X	DATE
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FOR EMPLOYER USE ONLY	DEPT/LOC #	HIRE DATE	EFFECTIVE DATE		
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