

# Flexible Benefits Plan

CROSBY BENEFIT SYSTEMS, INC.

# ENROLLMENT FORM

Once completed, please return this form to your Employer.

PLEASE PRINT CLEARLY:

## Employee Information

Employee Name \_\_\_\_\_ Employee Number: \_\_\_\_\_  
Last Name First Name MI  
Soc. Sec. No. \_\_\_\_\_ Date of Hire \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_  
City State Zip  
Home Telephone No. (\_\_\_\_\_) \_\_\_\_\_ Work Telephone No. (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
area code area code  
Employer Name **SMITH COLLEGE** Div./Loc./Dept./# \_\_\_\_\_

Payroll Mode:  Weekly  Bi-weekly  Semi-monthly  Monthly  Other

**Medical Care Reimbursement Account**  I elect to participate in the Medical Care Reimbursement Account program sponsored by my employer. Further, I elect to contribute \$ \_\_\_\_\_ Annually.  
 I elect not to participate in the Medical Care Reimbursement Program at this time.

**Dependent Care Reimbursement Account**  I elect to participate in the Dependent Care Reimbursement Account Program sponsored by my employer. Further, I elect to contribute \$ \_\_\_\_\_ Annually.  
 I elect not to participate in the Dependent Care Reimbursement Program at this time.

**Beneficiary Designation** In the event of my death, the person named below is my designated beneficiary:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Spouse and Dependent Information** If expenses for reimbursement are for your spouse or dependent children, please complete the following.

Person's Name	Relationship to Employee	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Employee Certification** I understand that my annual FSA election may require adjustment to comply with IRS section 125, 129 and 105 nondiscrimination guidelines. I also understand that I may not change or stop deposits to the account(s) indicated above until the end of the plan year unless I have a change in status, as defined by IRS regulations and my employer's plan. ***If I do not use all the money in my account(s) by the end of the year, I understand that any balance will be forfeited.*** I understand that there will be no interest build up in the account(s). I have read and understand the rules and regulations on the reverse side of this form.

My signature authorizes reductions from my pay checks for the purpose of funding my tax-free reimbursement account(s).

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

## FOR ADMINISTRATOR ONLY

Plan Year **2009** Effective Date **January 1, 2009**  
Authorized by \_\_\_\_\_ Date \_\_\_\_\_