

Flexible Benefits Plan ENROLLMENT FORM

CROSBY BENEFIT SYSTEMS, INC.

Once completed, please return
this form to your Employer.

PLEASE PRINT CLEARLY:

Employee Information

Employee Name _____ Employee Number: _____

Last Name First Name MI

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: **X - Bi-weekly**

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
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
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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).

X Employee Signature _____ Date _____

FOR ADMINISTRATOR ONLY

Plan Year 2010 Effective Date January 1, 2010

Authorized by _____ Date _____

MEDICAL	DEPENDENT**
ELIGIBLE EXPENSES:	ELIGIBLE EXPENSES:
<p>In general, an employee may be reimbursed for a health care expense which is deductible for federal income tax purposes, but which has not or will not be reimbursed by any other source, and which has not been or will not be deducted on the employee's income tax return. Some examples of eligible expenses include co-insurance and deductible amounts, and vision, hearing, dental and prescription drug expenses not covered by your health insurance.</p>	<p>The annual amount reimbursed cannot exceed the earned income of the lower-paid spouse or \$5,000, whichever is less. If you are married, filing separately, your annual reimbursement cannot exceed \$2,500.</p>
SUPPORTING DOCUMENTATION:	<p>The expenses must be employment-related and incurred for the care of a dependent of the employee who is under age 13 and for whom the taxpayer is entitled to a dependent deduction under Internal Revenue Code Section 151(c), or is a dependent of the employee who is physically or mentally incapable of caring for himself or herself.</p>
<p>The following forms of supporting documentation may be attached to the reimbursement request form:</p>	<p>The payments cannot be made to a person who is claimed as a dependent by the employee.</p>
<p>Expenses covered by your health care plan:</p>	<p>Expenses for DAY camp programs are allowable; however, if camp hours exceed the employee's working hours, submit ONLY that portion of expenses incurred for work-related hours. OVERNIGHT CAMP is NOT an allowable expense, even on a prorated basis.</p>
<p>Medical and dental expenses covered by your health care plan must be submitted to that plan. You may attach the Explanation of Benefits Statement to the reimbursement request form for the portion of your claim not paid by your health care plan.</p>	SUPPORTING DOCUMENTATION:
<p>For all expenses, you may attach bills or evidence of payment that clearly state all of the following:</p>	<p>The following supporting documentation should be attached to the reimbursement request form:</p>
<ol style="list-style-type: none"> 1. Name of person receiving the service 2. Nature of service or supplies 3. Name and address of provider of services 4. Out of Pocket Expense 5. Date service was rendered 	<ol style="list-style-type: none"> 1. Name of person receiving the service 2. Name and address of service provider 3. Amount charged 4. Date service was rendered 5. Provider's Tax ID Number

****QUALIFICATION GUIDELINES FOR A DEPENDENT CARE ACCOUNT**

To qualify, both the employee and spouse must be working, or one working and the other enrolled as a full-time student, or actively looking for work. If the employee is single, divorced or legally separated, the employee's need for dependent care assistance must be work related.

PLEASE NOTE

Service dates for reimbursable expenses must fall within the plan year. Reimbursement requests not submitted during the plan year must be submitted prior to the end of the runout period. Please contact your Human Resources Department or Crosby Benefit Systems for more information.

CROSBY BENEFIT SYSTEMS, INC.
617-928-0700 or 800-462-2235