

Benton County
Flexible Benefits Administration
ENROLLMENT AUTHORIZATION AND AGREEMENT



Phone: (541) 485-7488, (800) 422-7038
 Fax: (541) 485-8759, (800) 575-1109
 Web Address: www.manleyserv.com

Instructions: Please fill out this form completely, sign and date it, and return to Human Resources. Be sure to keep a copy of form for your records.

Employee Name		Date of Birth (Required)	
Address	City	State	Zip
Home Phone	Work Phone	Email	

PLAN YEAR: <u>August 1, 2010 – July 31, 2011</u>	Annual Maximums: Health Reimbursement Expense: \$3,000 per Plan Year Dependent Care Expense: \$5,000 per Calendar Year		
Flexible Spending Account	Per Pay Period Amount	Pay Periods	Annual Amount
I request the following amounts to be reduced from my paycheck.			
Health-Related Expense (HRE):	\$ _____	<u>X</u> _____	\$ _____
Dependent Care Expense (DCE):	\$ _____	<u>X</u> _____	\$ _____
Other Health-Related Premium (OHP):	\$ _____	<u>X</u> _____	\$ _____
Total Authorized Reductions:	\$ _____	<u>X</u> _____	\$ _____
Benny Card Enrollment: <input type="checkbox"/> YES - Fee \$1.50 per month <input type="checkbox"/> NO			

Beneficiary*	Relationship
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*Please designate someone over the age of 18 to be the beneficiary for your account. This person will be responsible for submitting claims in the event you are not physically able to do so. The beneficiary does not need to be related to you.

Premium Agreement for Unreimbursed Health-Related Expense Account

I *am* participating in the Unreimbursed Health-Related Expense Account. *Please read the following and sign below.*
 I *am not* participating in the Unreimbursed Health-Related Expense Account. *Do not sign below.*

I agree to participate in the Unreimbursed Health-Related Expense Account for the entire Plan Year. I understand that if my employment is terminated prior to the end of the Plan Year, the remaining monthly premiums will be taken from my final paycheck on a pre-tax basis, or in the alternative I agree to reimburse my employer (on a monthly basis) with after-tax dollars. If my final paycheck does not cover the remaining contributions, I agree to reimburse my employer the remaining balance (on a monthly basis) with after-tax dollars. I further understand that I have through the end of the Plan Year to incur eligible expenses, and may request reimbursement through the end of the normal run-out period as described in the Summary Plan Description.

Signature: Sign here *only* if you are participating in the Unreimbursed Health-Related Expense Account. **Date:** _____

AGREEMENT: I hereby certify the above information to be correct and true to the best of my knowledge, and that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the Plan Year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the flexible compensation reductions will be in effect for the Plan Year and cannot be revoked unless I experience a qualified change in status. I authorize my employer to withhold a portion of my pre-tax employment compensation and deposit these funds into my elected Section 125 spending programs as listed above:

EMPLOYEE'S SIGNATURE _____ DATE _____

EMPLOYER HR USE ONLY:
 Employee's Effective Date of Coverage: _____ Employee's First Payroll Date: _____