

MONMOUTH COLLEGE
FLEXIBLE SPENDING PLAN ELECTION FORM
 2011 Plan Year (January 1 through December 31)

Section I - Employee Information				
Employee-Last Name	First Name	Initial	Date of Birth	Participant ID Number
Street Address		City	State	Zip Code

Type of Election: Annual Election New Hire Family Status Change (see below)

Explanation for change in Family Status _____

Effective date of this election (date of first paycheck with flexible spending reduction) _____

Pay Period: Every Two Weeks (biweekly payroll*) Monthly

Section II - Flexible Spending Agreement

I hereby elect to have my salary reduced and a corresponding amount credited to my account in the Plan. Any previous election and compensation reduction agreement under the Flexible Spending Account relating to the same benefits is hereby revoked. I have read and understand the Summary Plan Description.

I agree to have my salary wages reduced as follows:

I authorize to have my premium contribution(s) for my employer-sponsored Medical Insurance (if any) withheld prior to taxes as provided in Section 125. This election will remain in force until revoked.

I authorize that my monthly earnings be reduced in the amount of \$_____ for other **medical/dental expenses**, for a yearly contribution of \$_____ (*Note: Contributions from biweekly [BW] payrolls will normally be deducted from the first two BW payrolls of each month). These would be expenses incurred which the health plan does not cover (i.e., deductibles, copayments, etc.). I understand I will only need to complete the claim form (attaching my bill, receipt or EOB) to receive reimbursement for any items not processed through the Monmouth College Health Plan, or if I am covered under more than one health plan.

I authorize that my monthly earnings be reduced in the amount of \$_____ for **dependent care expenses, (daycare)** for a yearly contribution of \$_____ (*Note: Contributions from biweekly [BW] payrolls will normally be deducted from the first two BW payrolls of each month). I understand I will need to submit a claim form to receive reimbursement. See reverse side for daycare contract.

I agree to notify the Company if I have reason to believe that any medical care expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand for any liability it may incur for failure to withhold federal and state income tax or Social Security tax from any reimbursement I receive on any non-qualifying expenses.

*****Automatic Rollover Payment Authorization*****

I understand that this document is also a claim form for expenses processed through the Monmouth College Health Plan and that any eligible amount unpaid will be rolled over the Flexible Spending Plan for reimbursement from my account.

By checking this box, I verify that expenses automatically submitted to the Flexible Spending Plan during the year are actual expenses for which I am liable and that these expenses are not eligible for reimbursement/payment under any other source. I agree to notify the Company immediately if I have reason to believe that any expense automatically rolled over does not qualify for reimbursement under the Flexible Spending Plan.

Employee's Signature	Date	Accepted by Monmouth College	Date
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Section III - Declining Flexible Spending Coverage

I hereby waive participation in the Monmouth College Flexible Spending Account Plan for 2011. I understand I will not be able to elect participation until the new plan year begins.

Employee's Signature	Date	Accepted by Monmouth College	Date
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COMPANY CONTRACT

Flexible Spending Dependent Care Annual Contract (This contract needs to be filled out yearly)

Terms of Contract

My Contract Year will begin on _____, and will end on _____.

EMPLOYEE NAME: _____ SS#: _____ / _____ / _____

Employee signature: _____

This form is being submitted to establish that a contract for services exists between me and the individual/entity who has signed below in which I have agreed to purchase dependent care services for the period indicated.

PROVIDER'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

I/We agree to provide day care services for the above mentioned employee. This service will be provided on the following basis:

Time Period	Frequency	Rate of Pay
_____ A.M.	Daily	\$ _____ Hourly
to	Weekly	\$ _____ Daily
_____ P.M.	Monthly	\$ _____ Weekly

Based on the above schedule, it is anticipated that the above mentioned employee will incur fees which will total, during the period stated above, a minimum of:

\$ _____

This statement is signed this _____ day of 2010

PROVIDER'S SIGNATURE _____ DATE _____

TITLE _____

PROVIDER'S SS# OR EIN# _____

Note: The IRS requires a W-10 form completed for services provided.

If the terms of this contract were to change at any time, you will need to contact us and a new contract will need to be filled out and sent to us.