

**MONMOUTH COLLEGE**  
**FLEXIBLE SPENDING PLAN ELECTION FORM**  
**2009 Plan Year (January 1 through December 31)**

<b>Section I - Employee Information</b>				
Employee-Last Name	First Name	Initial	Date of Birth	Social Security Number
Street Address	City		State	Zip Code
Type of Election: <input type="checkbox"/> Annual Election <input type="checkbox"/> New Hire <input type="checkbox"/> Family Status change Explanation for change in Family Status _____ Effective date of this election (date of first paycheck with flexible spending reduction) _____ Pay Period: <input type="checkbox"/> Biweekly (2 deductions per month/24 deductions per year) <input type="checkbox"/> Monthly				
<b>Section II - Flexible Spending Agreement</b>				
I hereby elect to have my earnings 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:				
<input type="checkbox"/> <b>Health Insurance Premiums:</b> I authorize to have my premium contribution(s) for Monmouth College Group Health Insurance (if any) withheld prior to taxes as provided in Section 125. This election will remain in force until revoked.				
<input type="checkbox"/> I authorize that my biweekly (limited to 24 deductions/year) or monthly earnings be reduced in the amount of \$_____ for other <b>medical/dental expenses</b> , for a yearly contribution of \$ _____ ( <b>\$5,000 maximum</b> ). These would be expenses incurred which the health plan does not cover (i.e., deductibles, co-payments, etc.). I understand I will only need to complete the attached 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.				
<input type="checkbox"/> I authorize that my every two weeks/monthly earnings be reduced in the amount of \$_____ for <b>dependent care expenses</b> , for a yearly contribution of \$ _____. I understand I will need to submit a claim form to receive reimbursement.				
I agree to notify Monmouth College 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 Monmouth College 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.				
<b>***Automatic Rollover Payment Authorization***</b>				
<input type="checkbox"/> I understand that this document is also a claim form for expenses processed through the Monmouth College Group 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	
<b>Section III - Declining Flexible Spending Coverage</b> (Do not decline if you are paying premiums through the MC Group Health Plan)				
I hereby waive participation in the Monmouth College Flexible Spending Account Plan for 2009. I understand I will not be able to elect participation until the new plan year begins.				
Employee's Signature		Date	Accepted by Monmouth College	

Please return your completed election to the Personnel Office (Poling Hall) by **December 31, 2008**.