



FLEXIBLE SPENDING ACCOUNT (FSA) FORM

JANUARY 1, 2008 -- DECEMBER 31, 2008

INSTRUCTIONS: THIS FORM MUST BE COMPLETED AND RETURNED ***EVEN IF*** YOU ARE ***NOT*** ENROLLING.

I WISH TO ENROLL IN THE CONFERENCE FSA I DO NOT WISH TO ENROLL IN THE CONFERENCE FSA

PLEASE COMPLETE ENTIRE FORM AND RETURN IT TO **THE CONFERENCE TREASURER'S OFFICE.**

Your Name _____ Social Security # _____
Street Address _____ Date of Birth _____
City _____ State _____ Zip Code _____

Work # _____ Home # _____
Fax # _____ E-Mail Address _____

Payroll Schedule: Weekly Bi-Weekly Semi-Monthly Monthly

PLEASE LIST DEPENDENTS YOU WILL BE SUBMITTING CLAIMS/RECEIPTS FOR.

Family	First, Middle Last	Relationship	Birth Date
1. Dependent	_____	_____	_____
2. Dependent	_____	_____	_____
3. Dependent	_____	_____	_____
4. Dependent	_____	_____	_____
5. Dependent	_____	_____	_____

PRE - TAX PAYROLL DEDUCTIONS OPTIONS

PRE-TAX INSURANCE PREMIUM CONTRIBUTION (Not Reimbursable) \$ _____

FLEXIBLE SPENDING ACCOUNTS (Reimbursable)

HEALTH CARE SPENDING ACCOUNT (check one) Maximum election of \$4,000.

- I wish to have \$ _____ withheld annually at \$ _____ per pay for eligible out of pocket Health Care Expenses for the plan year January 1, through December 31.
- I do not wish to participate in the Health Care Spending Account this year.

DEPENDENT (DAY) CARE SPENDING ACCOUNT (check one) Maximum election of \$5,000.

- I wish to have \$ _____ withheld annually at \$ _____ per pay for eligible out of pocket Dependent Care Expenses from January 1, through December 31. I understand that if I am married and filing a separate tax return, a lower maximum applies.
- I do not wish to participate in the Dependent Care Spending Account.

I understand that these accounts may only be used for my dependents as defined under the plan and that my choices above must remain in effect for the entire plan year unless I have a change in family status. I also understand that any unused balances in either account at the end of the plan year shall be forfeited. I hereby give my employer permission to reduce my salary by the above elected amount(s).

Signature

Date