



FLEXIBLE SPENDING PLAN

ENROLLMENT/CHANGE FORM

Plan Year: January 1, 2010 - December 31, 2010

Benefits Administered By
MVP Select Care, Inc
620 Erie Blvd. West #200, Syracuse, NY 13204
315.422.1533 ♦ 800.788.8771

Marist College
3399 North Road
Poughkeepsie, NY 12601
845-575-3349

TYPE OF ENROLLMENT

- Regular Annual Election
- Mid-Year Election **Effective Date:** ___/___/___
- Change in Family Status

If Mid-Year Election, date of first payroll deduction: ___/___/___

If change in family status, date of event: ___/___/___

Date of first payroll deduction after change becomes effective ___/___/___

If change in family status, change is due to: Divorce/separation

Marriage Birth or Adoption of child Death of spouse/child

Spouse becomes employed Spouse ceases to be employed

Change in work hours Unpaid leave of absence Other (explain below)

EMPLOYEE INFORMATION (please print)

Employee Name (last, first, middle initial)

Bi-Weekly Payroll Cycle: 26 Pay Periods

Semi-Monthly

Payroll Cycle: 24 Pay Periods

Street Address:

Phone Number:

City, State, Zip:

Marital Status: Married Single

Separated Divorced

Social Security Number:

Date of Birth:

I would like to receive reimbursement through direct deposit:

Yes No

If Yes, please complete Electronic Funds Transfer Agreement form.

PLAN YEAR ELECTIONS - PRE-TAX SALARY REDIRECTIONS

I authorize Marist College to deduct pre-tax contributions from my compensation for the following benefits:

Medical Reimbursement Account (reimbursement for family health care expenses not paid from any other source).

Dependent Care Reimbursement Account (day care expenses for eligible dependents)

NOTE: All contributions to Plan are subject to forfeiture if not claimed within 90 days after end of Plan Year.

Pre-Tax Deductions

Minimum FSA Election \$100, Maximum FSA Election \$5,000

Maximum Dependent Care Election \$5,000

To be completed by Human Resource Department

Total Annual Deduction

Number of Pay Periods

Per Pay Period Deduction

Medical Reimbursement

\$ _____

\$ _____

Dependent Care Reimbursement

\$ _____

\$ _____

If married & filing federal income taxes jointly, the maximum annual contribution amount allowed is \$5,000. If married & filing separate returns, the maximum annual contribution amount allowed is \$2,500.00. Amounts contributed to the Dependent Care Reimbursement Account reduce any available federal Child Care Credit.

Debit Card

I would like to receive the **take care**® Debit Card. I understand and agree that this card is only to be used to pay for qualified medical expenses that will not be reimbursed from another source. I understand that I am still responsible to acquire and retain documentation to substantiate any expenses. Yes No

Would you like to request a second free debit card for your spouse or dependent? Yes No
What name should appear on the second debit card? _____

Substantiation Requests

Email Address: _____

I do not have an email address and must receive requests for substantiation of reimbursement expenses via US Mail.

AUTHORIZATION OF PARTICIPATION

I request to participate in the benefits indicated above and hereby authorize my employer to make pre-tax deductions from my compensation in the amounts indicated. I understand that my elections indicated above are binding upon me for the entire Plan Year and cannot be revoked, modified or dependent care or health care expenses will be claimed by me as dependents on my federal and state tax returns. I further understand that future Social Security benefits may be affected should I elect pre-tax salary deductions under this Plan.

Employee Signature _____ Date _____

HR Representative _____ Date _____