Dependent Care Enrollment Form

PARTICIPANT INFORMATION

Full Name: ______________________________ (Last, First, Middle) **Social Security Number:** ____________________

Address: ______________________________ (Street, City, State, & Zip Code)

Home Phone Number: ____________________ Work Phone Number: ____________________

Date of Birth: ____________ Date of Hire: ____________________

Employer: CLARKSVILLE MONTGOMERY CO. SCHOOL SYSTEM Email Address: ____________________

Job Title: ____________________

Current Plan Year **2012**

Annual Contribution and Compensation Reduction Agreement

The Company and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each period during the plan year (or during such portion of the year as remains).

Please designate your per pay period and annual election amount you wish to contribute to your Dependent Care Spending Account for this plan year.

DEPENDENT CARE ACCOUNT - **Annual Limit $5,000 / $2,500 if filing separately**

$__________ x__________ Pay Periods = $_________ Plan Year Total
(Amount per pay period)

____PAY PERIOD 10 / MONTHLY
____'PAY PERIOD 20 / BI-WEEKLY

Annual Healthcare Amount
$ ____________

(Must equal total pay period deductions the participant has elected.)

Coding:
____ **03 - Classified**
____ **06 - Certified**
____ **09 - Administrative**

AUTHORIZATION: Please read the following statements and then sign and date this form.

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that the amounts deducted from my pay and not used for eligible health care or dependent care expenses incurred in the same year will be forfeited in accordance with IRS regulations.

I understand that this authorization is irrevocable until the next election period unless I have a change in status.

I also understand that this agreement is subject to the terms of the Company's Dependent Care Assistance Plan as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take this as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan (s). I further declare that I will not deduct these expenses on my federal income tax return.
I UNDERSTAND THAT ALL CLAIM PAYMENTS WILL BE DIRECT DEPOSITED INTO MY CHECKING ACCOUNT ON RECORD WITH MY EMPLOYER.

____________________ ____________________
Employee's Signature Date

Waiver of Participation

I decline to participate in the Health or Dependent Care Spending Accounts for the current plan year.

____________________ ____________________
Employee's Signature Date

Benefits Connection **P.O. Box 681569- Franklin, TN 37068-1569** **Local: (615) 224-1600** **Toll Free Fax: 877-239-6635** **Toll Free: 877-384-7539**

9/7/2011