



Flexible Spending Account Health 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: _____
Current Plan Year 2012	Job Title: _____

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 Health Care Spending Account for this plan year.

HEALTHCARE SPENDING ACCOUNT - Annual Plan Limit \$ 5,000

\$ _____ 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 Cafeteria Plan, Healthcare Reimbursement 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

BENEFIT 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

