Wabash College

Flexible Benefits Section 125 Plan

Benefit Election/Salary Reduction Agreement Form

PLAN YEAR EFFECTIVE DATE: January 1, 2009 through December 31, 2009

Section A - EMPLOYEE INFORMATION

Last Name	First Name	Middle Name	Social Security Number
Home Address	City		State
Home Phone	Sex: ( ) Male ( ) Female	Marital Status: Single Married	Date of Birth (MM/DD/YYYY)

YOU MUST CHOOSE TO <u>ELECT</u> OR <u>DECLINE</u> FOR EACH PROGRAM

Section B - PRE-TAX PREMIUM PAYMENTS FOR MEDICAL AND/OR DENTAL BENEFITS

( ) I hereby authorize Wabash College to reduce my salary for my share of Medical and/or Dental premium under the group health plan sponsored by the Employer by the method indicated below:

( ) I elect to have the above said premiums deducted from my pay on a pre-tax basis.

( ) I decline to have the above said premiums deducted on a pre-tax basis.
I understand I will not be eligible for pre-tax deductions until the next Plan Year. I understand that my current deductions for Medical and or Dental premiums will be deducted from my pay on a post tax basis which increases my tax liability and will most likely decrease my net take home pay.

( ) I do NOT have Medical or Dental Premiums deducted from my pay. Therefore, this section is not applicable to me.

Section C - WAIVER for Flexible Spending Account

I have been given the opportunity to enroll in the Flexible Spending Account program, but I desire not to participate at this time.

Employee's Signature **Date**

Section D-HEALTHCARE FLEXIBLE SPENDING PROGRAM-Section C

( ) I elect to participate in the Medical Flexible Spending Program.
I wish to have the following amount reduction from my salary and deposited into my Flexible Spending Account.
These funds can be used to reimburse expenses for me or any of my qualified dependents. **(List Qualified Dependents on Reverse Side)**
(Annual Maximum: $5,000)

Medical Flexible Spending Deduction Per <u>Pay Period</u> $_____________

Total Annual Deducation $ __________

To be Completed by Employer
Ded per pay period
# of pay periods (12 or 26)
Annual Amount
Date of 1st payroll ded.

( ) I decline to participate in the Healthcare Flexible Spending Program

Section E-DEPENDENT CARE PROGRAM-Section D

( ) I elect to participate in the Dependent Care Program. I wish to have the following amount reduction from my salary and deposited into my Dependent Care Account. (Annual maximum: $5,000, or if married and filing separate returns $2,500)

Dependent Care Deduction Per <u>Pay Period</u> $_____________

Total Annual Deducation $ __________

To be Completed by Employer
Ded per pay period
# of pay periods (12 or 26)
Annual Amount
Date of 1st payroll ded.

( ) I decline to participate in the Dependent Care Program.

ffective date
January 1, 2009 through December 31, 2009

PLEASE LIST DEPENDENT INFORMATION
ON REVERSE SIDE OF THIS FORM

Wabash College

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Please list Dependent Information Below

Dependent Name	DOB	Social Security Number

Signature Required	I have read all the enrollment literature explaining these benefits. I understand that any contributions to the account can only be used to reimburse eligible expenses under the account that were incurred during this plan year and that I forfeit any funds remaining in my account at the end of the plan year after all claims have been filed. I further understand that I may not change my contributions during the plan year unless I have a Qualifying Event. Furthmore, my Social Security benefits may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll deductions as contributions to my Dependent Care and/or Medical Flexible Spending Program as indicated above.

Employee's Signature	**Date**
Received by Employer	Date
Effective date	
January 1, 2009 through December 31, 2009	