Mott Community College

Flexible Spending Accounts
Benefit Election Form for the 2009 Plan Year

____ Enrollment or Re-Enrollment
____ Change in Family Status
____ Change of Personal Information
____ Termination of Employment

(Check all categories above that apply)

Personal Information

Last Name	First Name	Middle Initial	Social Security No.

Home Address: Street

City	State	Zip	Home Phone No.

E-Mail Address:	Date of Hire:

List of Dependents To Be Covered

Last Name, First Name, Middle Initial	Relationship	Gender	S.S.#	Birth Date	Issue Card Y/N

Benefit Elections

	Amount Per Pay Amount	Number of Pay Periods	Annual Election
1. Medical Spending Account (Maximum $3,000 annually)	1. $__________	X 26	= $___________
2. Dependent Care Spending Account (Maximum $5,000 annually or $2,500 annually for married individuals filing a separate return)	2. $__________	X 26	= $___________

I hereby apply for the options listed above. I authorize Mott Community College to adjust my pay as required by my election. I understand that the benefit options I have elected will remain in effect throughout the plan year, unless I have a change in family status. I also understand that any unspent money remaining in my account(s) at the end of the plan year will be forfeited.

I agree that if Mott Community College pays out of my Flexible Spending Accounts, any amounts which were not reimbursable, or which exceeded my annual plan limits (and/or monthly plan limits for the Dependent Care Account), upon discovery of such erroneous payments, Mott Community College may withhold amounts from my wages until the improperly paid amounts have been recovered in full.

_____________________________________ _________________________

Signature **Date**

November 2008