Lansing Community College
Human Resources Department

☐ Enrollment/ Re-enrollment

☐ Change in Family Status

FLEXIBLE SPENDING ACCOUNTS BENEFIT ELECTION FORM 2011-12 PLAN YEAR (11/1/11 – 10/31/12)

Personal Information:

Last Name | First Name | Middle Initial | Social Security Number

Home Address: Street | City | State | Zip Code

E-Mail Address | Home Phone Number | Date of Birth

List of Dependents to be Covered:

Relationship	Last Name	First Name	Gender	Social Security Number	Birthdate	Extra Card (Y/N*)

*** A charge of $10.00 will be assessed for each dependent card (debited out of your flexible spending account).**

Benefits Elections:

	Enter Per Pay Amount		Number of Pays		Annual Election
1. **Medical Spending Account** (Maximum $3,500 annually)	$______	x	26	=	$______
2. **Dependent Day Care Spending Account** (Maximum $5,000 annually, or $2,500 for married individuals filing separately)	$______	x	26	=	$______

* Dependents must be under age 13 to qualify for Dependent Care expenses under the FSA *

I hereby apply for the options listed above. I authorize Lansing Community College to adjust my pay as required by my election. I understand that the benefit options I have elected will remain in force throughout the plan year, unless I have a change in family status. I understand, also, that any money remaining in my account(s) at the end of the plan year will be forfeited. For Health Care FSA, I further understand and agree to the terms on the back of this form.

Signature | **Date**

PLEASE SEE REVERSE SIDE

Complete and return to Mail Code 8041-Human Resources

Flexible Benefit Plan
Payroll Reduction Agreement

HEALTH CARE REIMBURSEMENT AUTHORIZATION

I hereby consent to have my compensation reduced by the amounts indicated on the Election Form for my contributions to my Health Care/Reimbursement Account, and my signature on this form fully authorizes Lansing Community College to reduce my compensation in the indicated amounts.

I also agree that if I terminate my participation in the Health Care/Reimbursement Account Program, Lansing Community College may reduce, to the extent allowed by law, any wage, vacation or other compensable time payments owing to me by an amount equal to the difference, if any, between (1) the amounts by which I was reimbursed from my Health Care/Reimbursement Account prior to my termination date and (2) the amounts contributed by me to my Health Care/Reimbursement Account prior to my termination date. My signature on this form fully authorizes Lansing Community College to reduce any compensable time payments to me by the necessary amount.

I further agree that if Lansing Community College paid out of my Health Care/Reimbursement Account, whether by inadvertence or design, more than I was entitled to receive, Lansing Community College may withhold amounts from my wages until the improperly paid amount has been recovered. My signature on this form fully authorizes Lansing Community College to reduce my compensation to recover amounts improperly paid from my Health Care/Reimbursement Account.

I understand that the Election Form and this Payroll Reduction Agreement must be filed with Lansing Community College before the beginning of the Plan Year in order for it to be effective and that my election may not be modified during the Plan Year unless I have a change in family status, as defined by IRS rules.

I understand, also, that I may not take tax benefits on my annual 1040 tax returns for those monies utilized in this plan.