



Flexible Benefits Plan Enrollment Form

Voluntary Salary Reduction Enrollment

■ Plan Year 2009, Pay Periods 1-26 ■

PP

Employee Name (Please print)

Employee ID

Work Phone

Dept. Name

Dept. #

County E-mail Address

You may select all the options below, none of the options, or any combination of options.

Section A — Health Insurance Premium Co-payment

- I want my premium co-payment for self/dependent/part-time coverage to be a taxable deduction. Non-taxable salary reduction is automatically chosen for you. Check the box only if you want your deductions to be taxable.

Section B — Flexible Spending Account (FSA) Plans (You must re-select these options each year)

See the plan brochure for the forfeiture provisions if full balance is not used in this plan year (including the grace period). Also, see warning below. (You may use the Flex Plan Contribution Worksheet to determine your estimated annual amount.)

- 1. Health Care Flexible Spending Account** – for uninsured medical/dental/vision/over-the-counter and prescription expenses and deductibles, for you and your dependents but not for health insurance premiums.
Please Note: You cannot select this option if you have a Health Savings Account (HSA).
 - To enroll, enter the estimated annual amount you expect to spend for qualifying out-of-pocket healthcare expenses in 2009 (\$5,000 maximum).
 - This annual amount will be divided by the number of pay periods you will be working in 2009. If you are employed the full year, the annual amount will be divided by 26 pay periods and taken out of each paycheck in equal amounts.

2009 Annual Amount

\$ _____ . ____

- 2. Dependent/Child Care Flexible Spending Account** – for dependent/child care related expenses, but not for dependent medical/dental expenses.
 - To enroll, enter the estimated annual amount you expect to spend for qualifying dependent/care expenses in 2009 (\$5,000 maximum)
 - This annual amount will be divided by the number of pay periods you will be working in 2009. If you are employed the full year, the annual amount will be divided by 26 pay periods and taken out of each paycheck in equal amounts.

2009 Annual Amount

\$ _____ . ____

Section C — Term Life Insurance (This coverage will continue without re-enrollment each year until you cancel)

Premiums for the first \$30,000 coverage are pre-tax; for assistant department heads the pre-tax amount is \$20,000. All premiums for coverage over these amounts and all premiums for department heads, and for spouses and dependents are after-tax deductions. Employees must enroll in order to purchase coverage for their spouses or dependent(s). (BCS Enrollment Form required.)

I want the following life insurance coverage amounts:

- Self** Coverage amount: \$ _____ (total taxable and non-taxable) I want to CANCEL my existing Life Insurance for: (circle one) Self & Dependent(s) Spouse Dependent(s)
- Spouse** Coverage amount: \$ _____ (Limited to 50% of employee coverage)
- Dependent(s)** Coverage amount: Live birth to 6 months – \$1,000; 6 months to age 21 (age 26 if full time student) – \$5,000.

Section D — Accident Insurance (This coverage will continue without re-enrollment each year until you cancel)

Select one option to start or change your Accident Insurance coverage. You must also submit an Enrollment and Beneficiary Form* when you submit this form. Biweekly premium amounts are shown in the Personal Accident Insurance booklet.

- Self** Coverage amount \$ _____ Biweekly Premium \$ _____ I want to CANCEL my existing coverage.
- Self + Family** Coverage amount \$ _____ Biweekly Premium \$ _____

* All enrollment information and forms are available at www.sbcountyhr.org/benefits, the Employee Benefits Division or your payroll clerk.

IMPORTANT — Read Carefully Before Signing!

I have read the 2009 Flexible Benefits Plan information and understand that the selections I make will remain in place for the entire plan year (or longer for Life and Accident insurance), unless I have a qualified "change in status" as defined by the IRS.

If I choose to deposit part of my salary to a Health Care or Dependent/Child Care FSA, I understand that Internal Revenue Regulations require that claims can only be made to these accounts for services rendered between January 1, 2009 and March 15, 2010 (which includes the 2-1/2 month grace period.) Any amount remaining in these accounts after the claim filing period will be forfeited.

Employee Signature _____ Date _____