FLEX ENROLLMENT FORM

HAMPDEN-SYDNEY COLLEGE

For the Plan Year 1/1/2014 to 12/31/2014

PLEASE PRINT

Name: _____

Address: _____ Email: _____

_____ Social Security # _____

Indicate below the options in which you would like to participate.

I authorize my employer to make the following salary reductions:

□ **Health Care Reimbursement Account**

I elect to have an annual amount of $_____, which equals $_____ per pay period, reduced from my salary before taxes to reimburse me for eligible healthcare expenses I incur during the plan year specified above.

□ **Dependent Care Reimbursement Account**

I elect to have an annual amount of $_____, which equals $_____ per pay period, reduced from my salary before taxes to reimburse me for eligible dependent care expenses I incur during the plan year specified above.

Note: Reimbursement from this (and other dependent care plans for which you may be eligible) is limited to $5,000 per year or $2,500 per year if you are married filing separately. Reimbursement is further limited to earned income or your spouse's earned income, whichever is less.

I understand that:

- I cannot change this election during the plan year unless I have a change in family status.
- Any amounts remaining in my reimbursement accounts at the end of the year will be forfeited.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous elections and will terminate on the earlier of: 1) the end of the plan year, 2) when I am no longer a qualified employee eligible to participate in the plan, 3) termination of the plan.
- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I further understand, with regard to Benny Card transactions, that:

- Once I receive my Benny Card, I will only use it for payment of qualifying health and dependent care FSA expenses for myself or my eligible dependents.
- Any expense that I pay with the Benny Card will not have been reimbursed, nor will I be seeking reimbursement, under any other plan or program of benefit coverage.
- I must save all invoices and receipts for any expenses I pay with the Benny Card and upon request, will submit these documents for review by the plan.
- Each time I use or permit my Benny Card to be used for payment, I will renew and reaffirm the "My Use of Card Promises" that I will receive with the Benny Card.

LD&B is not allowed to discuss your account with your spouse or dependents (18 and older) unless you sign this form and list them below. This is due to the HIPAA regulations. To allow LD&B to release information to your spouse or dependents (18 and older) regarding processing claims, content of claims, account balances and any other information regarding your accounts, please list them below.

Signature: _____ Date: _____

Spouse's Name: _____

Dependent's (18 and older) Name: _____ Dependent's Name: _____

TO BE COMPLETED BY EMPLOYER

Eligibility Date: _____ Salary Reduction to Begin on Payroll Date: _____

Accepted By: _____ Date: _____