

\* Sign up within your first 30 days. Begins after first 90 days.



Enrollment Agreement  
2009 Plan Year

I wish to have my salary redirected for the period 1-01-09 through 12/31/09 in each of the categories below. I have received the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of the Columbia College Cafeteria Plan

Social Security Number \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name \_\_\_\_\_

(Last, First MI)

Street \_\_\_\_\_

City \_\_\_\_\_

State, Zip \_\_\_\_\_

	Per Pay Period	# of Pay Periods	Total for the Plan Year	Not to Exceed
Health Care Reimbursement Account	_____	<u>24</u>	_____	4,000.00
Dependent Care Assistance Account	_____	<u>24</u>	_____	5,000.00

\_\_\_\_\_ I DO NOT wish to participate in the TAX-FREE benefits of the Plan.

**DIRECT DEPOSIT REIMBURSEMENT (Flexible Spending Accounts only)**

I authorize ASI to credit my \_\_\_\_\_ (checking, savings) account number \_\_\_\_\_ at (name of bank) \_\_\_\_\_, with my Flexible Spending Account payments. Please attach a copy of a check or a void check and write the bank's routing number \_ \_ \_ \_ \_.

**E-MAIL**

\_\_\_\_\_ I wish to receive my notification of direct deposit reimbursement via e-mail over the Internet at the address below.  
E-mail address: \_\_\_\_\_

Employee's signature: \_\_\_\_\_

Date \_\_\_\_\_