WENATCHEE SCHOOL DISTRICT
HEALTH CARE AND DEPENDENT CARE
ACCOUNT ENROLLMENT FORM

Please Print or Type:

EFFECTIVE DATE: _____

FOR BENEFITS SECTION USE:

Employee Name – Last First MI

Social Security Number

Home Address

Email Address

City State ZIP Birth Date

Work/Home Phone

I understand that rules and regulations of IRC Section 125 allow an employee to redirect salary that is a payroll deduction into the following qualified benefits on a pre-tax basis. I hereby elect to participate in the employer's Health Care and/or Dependent Care Flexible Spending Accounts plan year **October 1, 2008 through September 30, 2009** as follows:

Please Check Your Elections(s):

BENEFIT ELECTIONS:	Participation	Amount Requested to Salary Redirection
1. Health Care Expenses (max: $2,400)	Yes No	$_____per pay period (#____ pay periods) (Annual Coverage Amount $_____)
2. Dependent Care Expenses (max: $5,000) **(Daycare Expenses <u>Only</u>)**	Yes No	$_____per pay period (#____pay periods) (Annual Coverage Amount $_____)

EMPLOYEE STATEMENT SIGNATURE:
I certify, that I have read and understood the enrollment form and descriptive material covering the **Health Care and Dependent Care Accounts** provided.

I understand that this enrollment form will remain in effect and cannot be revoked or changed during the Plan Year, unless the revocation and new election are on account of and consistent with a change in status. Further, my election on this enrollment form revokes any prior election relating to the same matter under the Plan. My participation in the Plan terminates on the last day of the Plan Year. Before the beginning of each Plan Year, I will be offered the opportunity to change my election for the following Plan Year.

I also understand that by offering this plan, the employer has provided no tax advice to me regarding participation in this plan; therefore, I agree to hold the employer harmless for any future taxes or penalties that may be imposed by the Internal Revenue Service due to future interpretations or changes in the laws governing the flexible benefits plan or flexible spending accounts.

I authorize and direct the employer to reduce my salary in the amount necessary to pay for the benefits shown above for the Plan Year. I understand that any amounts left in my reimbursement account after all claims have been paid at the end of the Plan Year will be forfeited.

YES, I would like to participate as indicated above.

X_____ _____

(Employee's Signature) (Date)