

**Participation and Salary Reduction Agreement**  
**Moravian College**

Plan year: January 1, 2010 through December 31, 2010

**I. Participant Identification (please print or type)**

Participant Name: \_\_\_\_\_ Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

**II. Agreement to Participate and Salary Reduction Agreement**

Please check below your benefit choices. Sign and date the form and return to the Benefits Coordinator.

Check the boxes for the benefits you are selecting and indicate the amount of salary reduction for each pay period for the Medical Flexible Spending Account and Dependent Care Flexible Spending Account.

I hereby authorize my employer to reduce my cash compensation as indicated below for each pay period during the Plan Year following the date of this agreement.

<u>Flexible Spending Arrangements</u>	<u>Salary Reduction Per Pay</u>	<u>Number of Pay periods</u>	<u>Annual Election</u>
<input type="checkbox"/> Dependent Care FSA (not to exceed \$5000.00 annually; \$192.30 per pay)	_____.	X _____	= _____.
<input type="checkbox"/> Medical Expense FSA (not to exceed \$3000.00 annually; \$115.38 per pay)	_____.	X _____	= _____.

**Waiver**

I decline participation in the Flexible Benefits Plan

I understand that this election form cannot be revoked or changed during the plan year, unless there is a change in my family status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and termination of employment of spouse) which justifies the revocation or change. I understand that salary reductions must be reimbursed for qualified expenses incurred during the plan year and may not be carried over into future plan years. If at the end of the plan year, the total reduction in compensation exceeds the substantiated expenses, the difference in amounts will be the property of the employer. I understand that I will be required to submit a separate written notice to my Employer to enroll in a Limited Plan if I have a family member who is making contributions to a Health Savings Account (HSA) under section 223 of the Internal Revenue Code.

I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agreed and accepted by  
The Employer's Representative

\_\_\_\_\_  
Date

(Admin. Only): Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
1<sup>st</sup> Withholding: \_\_\_\_/\_\_\_\_/\_\_\_\_