

Personal Choice Account®
Flexible Benefits Administration
ENROLLMENT AUTHORIZATION AND AGREEMENT
FOR
FM#0089 / LEWIS & CLARK COLLEGE
PLAN YEAR: From 4/1/08 To 3/31/09

Employee Name _____ SSN (Required) _____
 Address _____ DOB (Required) _____
 City _____ State _____ Zip _____
 Work Location _____ Work Phone (_____) _____

I authorize my employer to withhold a portion of my pre-tax employment compensation and deposit these funds into my elected PCA spending programs as listed below:

EMPLOYEE INSURANCE PREMIUM CONTRIBUTION

(Adjusted automatically to reflect group rate changes.)

\$_____ Per pay-period x _____ # of pay-periods = _____ Annual Election

HEALTH CARE SPENDING ACCOUNT

\$_____ Per pay-period x _____ # of pay-periods = _____ Annual Election

(Plan Year Maximum - \$6,000.00)

DEPENDENT CARE SPENDING ACCOUNT

\$_____ Per pay-period x _____ # of pay-periods = _____ Annual Election

(Cannot exceed the lower of husband's or wife's earned income. \$5,000 annual maximum if head of household or married filing jointly. \$2,500 annual maximum if married filing separately)

IN CONSIDERATION of my employer allowing me to participate in its Personal Choice Account (PCA), I acknowledge and agree as follows:

ACCEPT PCA PLAN TERMS: I agree to abide by the terms, conditions and provisions of the PCA contained in my employer's Plan Document, I acknowledge my right to examine the Plan Document or obtain a copy of it by giving reasonable advance notice to the plan administrator and paying a reasonable copy cost.

RESPONSIBILITY: I acknowledge that the Internal Revenue Code and PCA permit me to claim reimbursement only for my tax deductible expenses incurred after the effective date of my PCA elections and I assume full responsibility for all taxes, penalties, interest or other consequences which may be assessed to me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursements from PCA for disallowed expenses.

DEPENDENT CARE: I understand that the Internal Revenue Code prohibits me from claiming the Federal Child Care Tax Credit for dependent care assistance expenses which are reimbursed to me by PCA.

PLAN MODIFICATION: I have been informed that the PCA offered by my employer may be modified from time to time and I agree that my employer may cancel or amend the PCA according to their independent judgments and discretion without my consent or prior notice to me.

SOCIAL SECURITY: I choose to participate in PCA despite my knowledge that my salary reduction elections may reduce my FICA withholdings (Social Security) and that this may reduce my Social Security benefits upon retirement.

FORFEITURE: I understand that I must claim reimbursement for eligible expenses incurred during the plan year on or before 90 days after the last day of the plan year or I will forfeit those reimbursements. I further acknowledge that I will forfeit all funds credited to my PCA accounts which are not reimbursed to me.

*****Please note: Reimbursements must be RECEIVED by the last day of the run-out, not postmarked.**

SEEK ADVICE: I have been informed that my participation in PCA will have tax and economic consequences to me and that before deciding to participate in PCA I may wish to seek professional advice regarding the benefits, risks and limitations of PCA.

 EMPLOYEE'S SIGNATURE

 DATE

WAIVER OF PARTICIPATION: By my signature here _____, I acknowledge that the Personal Choice Account has been offered to me and I elect to not participate.

EMPLOYER HR USE ONLY: Complete this section for employees who join during the plan year

Employee's Effective Date of Coverage: _____ Employee's First Contribution Date: _____