COLORADO COLLEGE
CHILDREN'S CENTER – DEPENDENT CARE
FLEXIBLE BENEFITS PLAN ELECTION FORM

PLAN INFORMATION

Colorado College **Plan Year: January 1, 2008 – December 31, 2008**

EMPLOYEE INFORMATION

EMPLOYEE NAME

____ _____________________________________ ___________
LAST FIRST MI

EMPLOYEE HOME ADDRESS

____ ______________________________ _______ __________
NUMBER AND STREET CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER **DATE OF BIRTH** **EMPLOYEE TELEPHONE #**
____ ______/______/______ ______________________________________

EFFECTIVE DATE OF PLAN _________/_________/__________ (ONLY if different than beginning of Plan year above)

ELECTION INFORMATION

I understand that the rules of the Internal Revenue Code allow me to use part of my salary on a pre-tax basis to purchase the following qualified benefits. **I hereby elect to participate in my employer's Flexible Benefits Plan as indicated below.**

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCA)

Maximum of $5,000 per plan year if single parent or if married and filing a joint return.
Maximum of $2,500 if married and filing separately.

Pre-tax deduction per pay period $ __________________________

Annual pre-tax amount $ __________________________ (subject to the limits above)

I authorize CC to withhold the remaining tuition as a post-tax deduction from my paycheck.

____ I am paid 24 pay periods a year

____ I am paid less than 24 pay periods a year

I have read and understand the terms and conditions on the back of this page and in my company's Summary Plan Description. I understand that I can not change or revoke this election at any time during the plan year unless I have a Change in Status change (including marriage, divorce, death, birth or adoption of a child, change or termination of spouse's employment, change in dependent care provider or such other events as the Plan Sponsor determines will permit a change or revocation of an election). **I further acknowledge that I am responsible for keeping receipts verifying all eligible expense claimed under my employer's Flexible Spending Plan and must submit such receipts for claims substantiation upon request.**

☐ YES, the benefits of this Plan have been explained to me and I elect to participate as indicated above.

Participant's signature: ____ Date: ________________________________

TERMS AND CONDITIONS

Qualifying Medical Care and Dependent Care Expenses: I understand that reimbursement will be available only for "qualifying medical care expenses as listed under Section 213 and "qualifying dependent care expenses" as listed under Sections 129 and 21 of the Internal Revenue Code for me and my eligible dependents. These expenses **must be incurred while I am enrolled in the Plan**. I agree to notify the Plan Sponsor or Planned Benefit Systems, Inc. if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to repay the Plan on demand by way of check or payroll deduction for any expense for which I have paid for with either the *Flex Convenience®* card or have received a check from Planned Benefit Systems, Inc. that is not allowed under Sections 213, 129 or 21 of the Internal Revenue Code. I attest that I understand claimed medical expenses can not be reimbursed under the Health Care FSA Plan if the expense has been or will be paid in the future by any other plan and **acknowledge that the medical expenses have not been reimbursed or are not reimbursable under any other insurance plan coverage.** I further acknowledge that I am responsible for keeping all receipts, verifying all eligible expenses claimed under the Plan, and must submit such receipts to Planned Benefit Systems, Inc. for claims substantiation as required.

Participation Rules: I understand that reimbursement account eligibility; enrollment and benefits information is available from my Plan Sponsor. I authorize payroll deductions for the benefit elections indicated on this Election Form**. I understand that I cannot change or revoke this compensation reduction agreement at any time during the Plan Year except for the occurrence of a Change in Status**. **In case of a Change in Status, I must complete a Change Form no later than 30 days after the date of the Change in Status occurs if I want to enroll in a reimbursement account or change my reimbursement account elections or amounts**. Any amounts remaining in the account(s) represented by this Election Form at the end of the Plan Year, past the claims filing limit will be forfeited to the Plan under the guidelines of the Internal Revenue Code. Expenses incurred prior to my plan enrollment date are not eligible for reimbursement.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE PLAN SPONSOR'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME IN EFFECT; SHALL BE GOVERENED BY AND CONSTRUED IN ACCORDANCE WITH APPLICALBE LAWS; SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).