

**CLACKAMAS COUNTY
FLEXIBLE SPENDING ACCOUNTS ENROLLMENT FORM**

PLAN YEAR: JANUARY 1, 2011 - DECEMBER 31, 2011

REPRESENTED

NEW ENROLLMENT FAMILY STATUS CHANGE OPEN ENROLLMENT

EFFECTIVE DATE

/ / 2011

EMPLOYEE NAME (Last, First MI)		DEPARTMENT/DIVISION	EMPLOYEE ID
STREET ADDRESS			SOCIAL SECURITY
CITY, STATE, ZIP			BIRTH DATE
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	HOME PHONE		WORK PHONE
<input type="checkbox"/> HEALTH CARE		<input type="checkbox"/> DEPENDENT CARE	
\$5000 PLAN YEAR MAXIMUM 26 Pay Periods		\$5000 CALENDAR YEAR MAXIMUM 26 Pay Periods	
PLAN YEAR CONTRIBUTION \$ _____ \$ _____	PLAN YEAR CONTRIBUTION \$ _____ \$ _____		

ELIGIBLE FAMILY MEMBERS

NAME (LAST, FIRST MI)	GENDER	BIRTH DATE	HEALTH CARE	DAY CARE

AUTHORIZATION

I agree not to deduct or claim credit for any of the expenses reimbursed through the FSA on my income tax return. I understand that:

- * If I am married and file a separate return, my dependent care contributions cannot exceed \$2500, unless I am considered unmarried for tax purposes.
- * The Flexible Spending Accounts are subject to current Federal government regulations and to any future tax changes required by the government.
- * Salary reduction amounts will not be subject to Social Security (FICA) taxes and may marginally reduce my Social Security benefit upon retirement.
- * **Use It or Lose It:** Amounts remaining in my Flexible Spending Account(s) at the end of the plan year will be forfeited. However, eligible charges incurred during the plan year may be submitted for reimbursement within 90 days following the end of the plan year.
- * The official Plan Document legally governs the Flexible Spending Accounts.
- * Clackamas County reserves the right to cancel or modify the Flexible Spending Account plan.

Signature _____ Date _____