

State of Ohio FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start a tax-free Medical Expense and/or Dependent Care Flexible Spending Account.
For Open Enrollment Only: You may enroll online at www.myFBMC.com

Please press hard with ballpoint pen. The bottom copy is yours.

Name (Please Print) Last		First	MI	Social Security #		
Home Address Street		City	State		ZIP	
Daytime Phone ()	Home Phone ()	Date of Hire	Date of Birth		Annual Salary	
E-mail Address						
ENROLLMENT STATUS: <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> RE-ENROLLMENT <input type="checkbox"/> CHANGE IN STATUS <input type="checkbox"/> NEW HIRE						
CHANGE TYPE: _____ DATE: ____ / ____ / ____						

- Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
- Complete the worksheets provided in your 2009 Flexible Benefits Plan Reference Guide before deciding on the amount.
- If you have questions, consult your 2009 Flexible Benefits Plan Reference Guide, or call FBMC Customer Service at 1-800-342-8017.
- Be sure to submit your enrollment form by October 31, 2008. Pertains to Open Enrollment only.
- Your effective date will be the first of the month after FBMC receives your enrollment form. Open Enrollment effective date is January 1, 2009.

In Box #1, indicate the dollar amount you elect to contribute for the 2009 plan year.

In Box #2, indicate the number of regular payroll checks you expect to receive during the 2009 plan year.

In Box #3, indicate the deduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding.)

By signing this form you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, or for planned retirement, or any other anticipated leave.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Use your Health Care FSA for eligible uninsured, out-of-pocket medical expenses incurred by you, your family members or both.
(Annual allowable maximum contribution per participant is \$3,000)

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
24 for employees paid bi-weekly
12 for employees paid monthly ÷ _____

Box #3
Reduction per regular paycheck = _____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

TAX FILING STATUS— PLEASE CHECK ONE:

- Married, filing separately [maximum - \$2,500] Married, filing jointly [maximum - \$5,000] Single, head of household [maximum - \$5,000]

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
How many consecutive pay periods for payroll deduction? _____
Employees paid bi-weekly (max of 24)
Employees paid monthly (max of 11) ÷ _____

Box #3
Reduction per regular paycheck = _____

I choose to receive an EZ REIMBURSE® MasterCard® Card. There is a \$20 annual fee upon activation.

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before Medicare, local, state and federal income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment before the end of the plan year or file an approved Change In Status Election Form with the contract administrator within 30 days of the event.
- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this Enrollment Form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE

DATE SIGNED

SUBMIT YOUR COMPLETED FORM TO FBMC AT P.O. BOX 1878, TALLAHASSEE, FL 32303.

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES
------------	--------------	---------	---------	---------------