

## Flexible Spending Account Enrollment Form

### Employee Information

Last Name	First Name	M.I.	Social Security Number
Mailing Address Number	Street	Apt.	Daytime Phone (       )
City			State      Zip Code

### FSA Election Plan Year 1/1/2009 to 12/31/2009

### FSA Plan Benefit Amount

#### Health Care FSA

I elect to participate. My annual contribution is \$ \_\_\_\_\_

Minimum Plan Year Contribution Amount: **\$120.00**

I elect not to participate.

Maximum Plan Year Contribution Amount: **\$5,000.00**

#### Dependent Care FSA

I elect to participate. My annual contribution is \$ \_\_\_\_\_

Minimum Plan Year Contribution Amount: **\$120.00**

I elect not to participate.

Maximum Plan Year Contribution Amount: **\$5,000.00\***

\* If you are married and file jointly, your combined contributions may not exceed \$5000.00.  
If you are married and file separately, your individual contributions may not exceed \$2500.00.

### Authorization

I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my elections above, with the "tax protected" funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year, unless I experience an eligible change in status. I further understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year. Any unused amounts remaining in my account at the end of the plan year will be forfeited. However, I will have a specified period of time (indicated in the FSA enrollment materials) after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year or coverage period.

Employee Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Employer Use			
Company Name Loyola University New Orleans	Division	IBC	Effective Date
Client ID L02571	Plan Year From 1/1/2009 to 12/31/2009	Pay Code	