Flexible Spending Account Enrollment Form

Employee Information

Please provide your SSN if you are completing this form as part of your first Ceridian FSA election. Otherwise, you may provide your Account ID. Your Account ID is the 10 digit number found on most FSA correspondence from Ceridian. Please include the leading zeros. Example: 0000012345	Account ID |___|___|___|___|___|___|___|___|___|___| Social Security Number |___|___|___|___|___|___|___|___|___|

Last Name	First Name	M.I.

Mailing Address Number Street Apt.	Daytime Phone
	( )

City	State	Zip Code

FSA Election Plan Year 1/1/2010 to 12/31/2010 FSA Plan Benefit Amount

Health Care FSA

☐ I elect to participate. My annual contribution is $_____

☐ I elect not to participate.

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

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

Dependent Care FSA

☐ I elect to participate. My annual contribution is $_____

☐ I elect not to participate.

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

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.

I also certify that I, and my spouse and/or dependent(s) if applicable, will only use the Flexible Spending Account Card that I will receive in connection with employer's Health Care Flexible Spending Account Plan and in Section 213 of the Internal Revenue Code. I further certify that I will not seek reimbursement from any other plan for any medical expense paid with the Flexible Spending Account Card, nor will I claim any federal income tax deduction or credit with respect to such expense.

Employee Signature **X**_____ Date _____

Employer Use

Company Name	Division	IBC	Effective Date
Loyola University New Orleans (C1)			

Client ID	Plan Year	Pay Code
L02571	From 1/1/2010 to 12/31/2010	

Medical Plan	Dental Plan	Vision Plan	Drug Plan	Other Plan	Other Plan	Other Plan	Other Plan