

FLEXIBLE BENEFITS PLAN

FLEXIBLE SPENDING ACCOUNTS (FSA) ENROLLMENT ELECTION FORM

Instructions: Estimate your expenses and complete Sections I, II, III, and IV of this form.

I. IDENTIFYING INFORMATION (Please Print)

Last Name	First Name	Middle Initial	Social Security Number
Address			Date of Birth
City	State	Zip Code	Mail Stop
		Phone Ext.	\$ _____ Salary (needed to determine DCA Employer Credit, if applicable)

Indicate the Plans you will participate in and your annual deductions for each. FSA contributions are deducted from your pay two times per month for a total maximum of 24 deductions per Plan Year.

II. HEALTH CARE ACCOUNT ELECTION

I elect to participate in the Health Care Account (HCA). I will only use the salary reduction to pay for qualifying medical expenses as described in the HCA Summary Plan Description. I authorize the Plan Administrator to reduce my taxable compensation by: *(Limited to \$5,000 annually, \$120 minimum annually.)* If you enroll in a high deductible health plan under the Federal Employees Health Benefits Program and open a Health Savings Account (HSA), you *cannot* participate in the HCA program. HSA are qualified accounts to help pay your unreimbursed medical expenses

Plan Year Amount
\$ _____

III. DEPENDENT CARE ACCOUNT ELECTION

I elect to participate in the Dependent Care Account (DCA). I understand that to participate in the Dependent Care FSA **all** of the following must be true:

- I (or we, if you are married) will not claim the dependent care tax credit for expenses paid from my DCA account.
- My taxable (W-2) income at the end of the plan year will exceed the amount of the salary reduction I am electing, and, if applicable, my spouse's taxable income at the end of the plan year will exceed the amount of salary reduction I am electing.
- I (or we, if you are married) do not contribute or receive employer contributions for dependent care assistance from another employer's FSA plan that, when combined with the Board's FSA plan, would exceed the \$5,000 limit.
- If I am married, and elect a salary reduction in excess of \$2,500, I will not file a Year 2006 federal income tax return separate from my spouse.
- I will only use the salary reduction to pay for "qualifying expenses," i.e., expenses to care for an individual who is:
 - under the age of 13 and for whom I am entitled to take a deduction on my tax return. (I understand my child is ineligible when he or she turns age 13); or
 - a dependent or spouse (or individual who regularly spends at least 8 hours a day in your household) who is physically or mentally incapable of caring for himself or herself.
- If I obtain care from one or more dependent care centers (centers that provides care for more than 6 individuals for a fee) I will report the name, address, and, if applicable, taxpayer identification number of each dependent care center on my tax return. If I use a center or provider who provides care for less than 6 individuals, I do not need to report their information on my tax return, however, I can still reduce my salary by a maximum of \$5,000 for dependent care expenses.

I agree that I meet all of the above conditions and I elect to participate in the plan. I authorize the Plan Administrator to reduce my taxable compensation by: *(Total for plan year—\$5,000 maximum, including employer credits if applicable. Married participants are limited to \$5,000 maximum annual family dependent care amount.)*

Employer credit:

\$1,000 (for salary less than \$100,000)

\$ _____
Employee contributions only

\$ _____
Employer credit amount

\$ _____
Total pledge

Total DCA amount *(Limited to \$5,000 annually, \$120 minimum annually)*

IV. SIGNATURE

My signature certifies that I have not knowingly provided false information on this form. It also certifies that I have read the terms and provisions statement of this form, I have received a copy of the FSA Summary Plan Description, and I understand and agree to the terms of the plan.

Employee Signature _____ Date _____

V. ADMINISTRATOR'S CERTIFICATION AND ACCEPTANCE OF ELECTION

I certify that the above-named employee is eligible to participate in this plan and that the election is in accordance with the plan.

Authorized Signature _____ Date _____

Participation Effective Date _____ Payroll Effective Date _____

PeopleSoft Code: HCFS A DCGRP1 = \$1,000 Credit
DCGRP4 = No Credit

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM
FLEXIBLE BENEFITS PLAN
FLEXIBLE SPENDING ACCOUNTS (FSA) ENROLLMENT ELECTION FORM

2007 Plan Year

TERMS AND PROVISIONS

By signing and submitting this form, I understand that:

- I am making a binding election for the plan year that, in most cases, CANNOT be changed or withdrawn during the plan year;
- Any contributions on my behalf must be used by me for qualifying expenses incurred during the plan year, and any funds not used will be forfeited by me;
- I have received and read a copy of the summary plan description that explains the plan that controls my obligations and the obligations of the Board. The Plan Document will control over any discrepancy between that document and any other information that may have been provided to me;
- I may obtain a copy of the plan;
- If I go on Leave Without Pay Status, I may be responsible for making certain payments to the Administrator and my reduction in compensation may be increased by the Administrator, without further authorization by me;
- The benefits I receive under this plan may, in rare circumstances, be subject to state and federal taxes; and
- I am responsible for providing other information to the Administrator that may be necessary to process a claim, or for federal and state reporting purposes.
- I do not have a Health Services Account (HSA).

Privacy Act Statement: The information you provide on this form is needed to document, in your personnel, payroll, and retirement records file, your election to participate or waive participation in the FSA. This information will be shared with any individual or entity used by the Administrator to assist in the administration of the FSA and it will be used: (1) to identify you, (2) to verify your eligibility for payment of a claim under the FSA, and (3) to determine how the Board must classify benefits received by you from the FSA for tax purposes. This information may also be disclosed to other Federal agencies and Congressional offices that have a need for the information in connection with your application for a job, license, grant, or other benefit. It may also be shared with national, state, local, and other charitable or social security administrative agencies for those

agencies to determine and issue benefits under their programs. To the extent this information indicates a possible violation of civil or criminal law, it may be shared with the appropriate federal, state, or local law enforcement agencies. The information may be disclosed in legal proceedings in connection with your employment at the Board. Executive Order 9397, November 22, 1943, authorizes the use of your Social Security Number to distinguish you from people with similar names. Maintenance of this information is authorized by Section 10 of the Federal Reserve Act (12 USC 244). Furnishing your Social Security Number and other information is voluntary, but your failure to do so may result in a delay in the receipt of benefits, and may result in the reclassification of any benefits you receive.