

**ELECTION TO PARTICIPATE
SIMPSON COLLEGE TAX SAVER 125 PLAN
(2009-10)**

(Please Print)

Name _____ SS# _____

Birthdate _____ Hire Date _____ Benefit Date _____

I understand that the Simpson College Tax Saver 125 Plan allows me to choose from the following menu of benefits and pay for them with **before-tax dollars through payroll reduction**. In accordance therewith, I hereby elect the following benefits for the Plan Year July 1, 2009 - June 30, 2010:

CIRCLE

A. **HEALTH AND/OR DENTAL & VISION INSURANCE PREMIUM(S)** YES NO

PARTICIPANT SIGNATURE DATE

B. REIMBURSEMENT ACCOUNTS

1. **TRADITIONAL MEDICAL REIMBURSEMENT ACCOUNT** YES NO
(\$3,000.00 Annual Limit)

ANNUAL AMOUNT \$ _____ / 12 PAY PERIODS = \$ _____ PER PAYPERIOD
(This plan is only for non-HSA participants)

I understand that in the event that I terminate employment during the Plan Year, I cannot submit any claims for expenses incurred after the termination date, unless I elect COBRA Continuation Coverage and continue to contribute to my Traditional Medical Reimbursement Account.

PARTICIPANT SIGNATURE DATE

2. **LIMITED PURPOSE MEDICAL REIMBURSEMENT ACCOUNT** YES NO
(\$3,000.00 Annual Limit)

ANNUAL AMOUNT \$ _____ / 12 PAY PERIODS = \$ _____ PER PAYPERIOD
(This plan covers only dental & vision for HSA participants only)

I understand that in the event that I terminate employment during the Plan Year, I cannot submit any vouchers for claims incurred after the termination date, unless I elect COBRA Continuation Coverage and continue to contribute to my Limited Purpose Medical Reimbursement Account.

PARTICIPANT SIGNATURE DATE

3. **DEPENDENT CARE REIMBURSEMENT ACCOUNT** YES NO
(\$5,000 Annual Limit married filing jointly, \$2,500 married filing separately or single head of household)

ANNUAL AMOUNT \$ _____ / 12 PAY PERIODS = \$ _____ PER PAYPERIOD

I understand that, for any given reporting period, any reimbursement I receive from the program will not exceed the balance in my Dependent Care Reimbursement Account. If I should terminate employment during the Plan Year, I understand that I can continue to submit expenses through the end of the Plan Year until I have received my remaining Dependent Care Reimbursement Account balance; however, I will no longer be permitted to make contributions to my Dependent Care Reimbursement Account.

PARTICIPANT SIGNATURE DATE

I hereby authorize payroll reduction:

PARTICIPANT SIGNATURE DATE

I hereby elect **not** to participate:

SIGNATURE DATE