



DELTA HEALTH SYSTEMS
Delivering as Promised...since 1968

Diocese of Monterey
FLEXIBLE SPENDING ACCOUNT

**Enrollment/Election Form
Plan Year 2009**

Name: _____

Address: _____

Social Security Number: _____

Plan Year: January 1, 2009 through December 31, 2009

As an eligible participant in the Flexible Spending Account, I elect the following benefits and designate the following amounts for each benefit I have selected. The Employer and I agree that my compensation will be redirected by the amounts set forth below for the plan year.

ELECTION OF HEALTH CARE REIMBURSEMENTS

I elect to receive health care reimbursements for the 2009 plan year.

Amount of Annual Salary Redirection: _____

(Maximum \$2,500.00)

- I understand that reimbursement will be available only for 'qualifying health care expenses' as described in the Summary Plan Description.
- I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.
- I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

(See reverse for Dependent Care and Required Signature)



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**Diocese of Monterey
ELECTION OF DEPENDENT CARE ASSISTANCE**

I elect to receive dependent care assistance for the 2009 plan year.

Amount of Salary Redirection: \$ _____
((\$5,000.00 Maximum))

- I understand that reimbursement will be available only for ‘qualifying dependent care expenses’ as described in the Summary Plan Description.
- I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.
- I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

OTHER TERMS AND CONDITIONS

I understand that:

- The pre-tax pay reduction may not be effective for any pay period that begins before I have signed this form and returned it to the Human Resources Department.
- I cannot change or revoke this compensation redirection at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- The Plan Administrator may reduce or cancel the amount of pay reduction or otherwise modify this agreement in accordance with the Flexible Spending Account if he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans.
- Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year.

Employee’s Signature

Date

Accepted and Agreed to by Diocese of Monterey

By: _____

Date: _____

(See reverse for Health Care)