



Premier Benefits Solutions
P.O. Box 1878 Tallahassee, FL 32302-1878

Landrum Professional Employer Services
Plan Year January 1, 2009 to December 31, 2009
FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start or continue a before-tax Medical Expense and/or Dependent Care Flexible Spending Account.

Name (Please Print) Last		First		MI	Social Security #			
Home Address Street			City		State		ZIP	
Daytime Phone () ()		Home Phone () ()		Date of Hire	Date of Birth		Annual Salary	Work Location
ENROLLMENT STATUS: <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> CHANGE IN STATUS <input type="checkbox"/> NEW HIRE				Employee ID #		Effective Date (Benefits Department use only)		
E-Mail Address:				Worksite Employer				

Indicate the amount you wish to pay through before-tax salary deduction by completing the sections below. Complete the worksheets provided in your Reference Guide before deciding on the amount. If you have questions, consult your Reference Guide or call FBMC Customer Service at 1-888-868-5188.

In Box #1, indicate the dollar amount you elect to contribute for the plan year.

In Box #2, indicate the number of regular payroll checks with deductions you expect to receive during the plan year.

In Box #3, indicate the deduction amount per paycheck. (Note: if Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding).

By signing this form, you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, or for planned retirement, or any other anticipated leave.

MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT*	
For uninsured eligible medical expenses incurred by you, your family members, or both.	
Box #1 Total Plan Year Dollar amount from your worksheet (Total Plan Year Contribution)	_____
Box #2 Number of regular paychecks expected**	_____
Box #3 Reduction Per Regular Paycheck	_____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT*	
For uninsured eligible dependent care expenses incurred by you, your family members, or both.	
Box #1 Total Plan Year Dollar amount from your worksheet (Total Plan Year Contribution)	_____
Box #2 Number of regular paychecks expected**	_____
Box #3 Reduction Per Regular Paycheck	_____

* For your Minimum and Maximum Contribution Limit please contact the Benefits Department at Landrum Professional Employer Services.

** To confirm the number of paychecks during your plan year please contact the Benefits Department at Landrum Professional Employer Services.

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal and state income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any FSA not used during this plan year will be forfeited after the 2½-month grace period.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment before the end of the plan year or file an approved Change In Status Election Form with the contract administrator within 30 days of the event.

- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this Enrollment Form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

Employee Signature	Date Signed
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**Submit your completed Enrollment Form to the
Landrum Professional Employer Services, Benefits Department or Fax to 850-476-2177**

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES
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