



2009

Cafeteria / FlexPlan Enrollment Form

Employee Last Name	First Name	Middle Initial	
Employee Address	City	State	Zip
Social Security Number			

I wish to pre-tax the following Group Insurance Plans:

Health Insurance	Dental Insurance	Optional Vision Insurance
Employee <input type="checkbox"/> \$ 39.40 / month	Employee <input type="checkbox"/> \$ 3.08 / month	Employee <input type="checkbox"/> \$10.21 / month
Employee/*Spouse <input type="checkbox"/> \$170.80 / month	Employee + 1 <input type="checkbox"/> \$12.80 / month	Employee + 1 <input type="checkbox"/> \$18.35 / month
Employee/Child(ren) <input type="checkbox"/> \$151.20 / month	Employee + 2 <input type="checkbox"/> \$19.68 / month	Employee + 2 <input type="checkbox"/> \$26.83 / month
Employee/*Spouse & Child(ren) <input type="checkbox"/> \$212.40 / month	or more	or more
Decline <input type="checkbox"/> **Receive monthly flex credits	Decline <input type="checkbox"/> **Receive monthly flex credits	Decline <input type="checkbox"/> - 0 -

* Domestic Partner coverage cannot be paid on a pre-tax basis and College contribution to domestic partner coverage is fully taxable to employee.

** Flex credits will transfer to the monthly cost of the *spouse's plan in the event that an employee who elects to decline coverage has a *spouse who is employed at Grinnell College and that *spouse has elected to enroll in the Employee/*Spouse & Child(ren) plan. Flex credit *cash* is subject to federal and state taxes.

Flexible Spending Accounts

Medical

Annual Election	Number of Pay Periods (monthly = 12; bi-weekly = 24)	Per Pay Period Deduction
\$ _____ ÷	_____ =	\$ _____

Dependent Care

Annual Election	Number of Pay Periods (monthly = 12; bi-weekly = 24)	Per Pay Period Deduction
\$ _____ ÷	_____ =	\$ _____

Authorization: I certify the above information to be true to the best of my knowledge and that the children on whom I will be claiming dependent expenses or child care either reside with me in a parent-child relationship or are legally dependent on me for their support. I certify that if I elected more than \$2,500 for Dependent Day Care, I am single, or I am married filing a joint income tax return with my spouse. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire plan year and cannot be revoked unless I experience a change in my family status or termination of employment.

Signature _____

Date _____

For Office Use Only

New Enrollee Renewal / Change

Effective Date of Enrollment: _____

First Payroll Deduction Date: _____

Plan Year 2009