

**CARROLLTON-FARMERS BRANCH ISD  
FLEXIBLE BENEFIT PLAN  
ELECTION FORM  
SHORT PLAN YEAR JANUARY 1, 2010-August 31, 2010**

**UNITEDHEALTHCARE-  
Third Party Administrator**

**1. Employee Information**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_ Campus \_\_\_\_\_  
 Marital Status: Married Single Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

**2. Spouse/Dependent Information (Section 125 Benefits Only)**

| Last Name | First Name | Soc. Sec # | Date of Birth | Relationship |
|-----------|------------|------------|---------------|--------------|
| _____     | _____      | _____      | _____         | _____        |
| _____     | _____      | _____      | _____         | _____        |
| _____     | _____      | _____      | _____         | _____        |

**3. Premium Only Account - Pre-Tax Premiums** - This option allows you to pay any medical, dental or vision premiums on a pre-tax basis. Eligible deductions will be deducted from your paycheck before taxes. "Yes" indicates you want to pay pre-tax and "No" indicates your want your premiums paid with after tax dollars. **Current election for pre-tax premiums will continue unless you make a change for January 2010.**

Yes  No

**4. Employee Contribution**

I elect to make contribution(s) on a pre-tax basis to my Flexible Spending Account for this short plan year and I authorize salary deduction(s) of the following amount(s) per pay period.

**Options:**

|   | Annual Pledge | # of Pay Periods | Pledge Per Pay Period |
|---|---------------|------------------|-----------------------|
| A. Medical Reimbursement Contribution (Medical use only)  | \$ _____ ÷    | 8                | \$ _____              |
| B. Dependent Care Account Contribution (Day Care Use Only)                                      | \$ _____ ÷    | 8                | \$ _____              |
| <b>***Maximum contribution for January through August is \$3200 each for A and B Options***</b> | <b>TOTAL</b>  |                  | \$ _____              |

**5. Employee Authorization – Very Important – Read Carefully**

I understand the maximum amount, which may be contributed to my Medical Reimbursement Account, is \$3,200 for January 1, 2010 through August 31, 2010. The maximum contribution for Dependent Care Account for the same period is \$3,200. Maximum amount for calendar year is 5,000 (\$2,500 if married filing separate tax return) per plan year. I understand that I am not permitted to change my election during the plan year, with the exceptions restricted to certain restricted IRS regulations for change in status events. If enrolling in the Dependent Care Account, I acknowledge that I intend to file Form 2441 with the IRS, including the name, address and tax ID number of the provider of dependent care services, and that if I have elected to receive more than \$2,500 that I am either unmarried or if married that I do not intend to file a separate federal tax return. I also understand that unused funds at the end of August 2010 can be carried over to the following plan year beginning September 1, 2010. The funds must be used within 75 days or the funds will be forfeited in accordance with rules and regulations established by the IRS. I hereby certify that the above information is complete and true and I authorize C-FBISD to make any required payroll deductions on a pre-tax basis and should I terminate my employment during this plan year, I may cease making contributions and, unless I elect to continue participation through COBRA coverage, will thereby cease participation in this plan.

Employee Signature \_\_\_\_\_ (Do not sign before reading above information) \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY:**

Effective Date \_\_\_\_\_ Total Contribution/ Pay Period: \_\_\_\_\_ Date Sent to UHC \_\_\_\_\_