

ENROLLMENT FORM
MOUNT HOLYOKE COLLEGE SPENDING ACCOUNTS
PLAN YEAR JANUARY 1, 2010 - DECEMBER 31, 2010

Name: _____ Social Security #: _____
Last First Middle

Home Address: _____
Street City State Zip

Home Phone: _____ Email: _____ Pay Frequency: Monthly _____ Biweekly _____

Health Care Spending Account *(please complete the appropriate spaces):

Plan: FSAM

- I elect to contribute \$ _____ per pay period X _____ pay periods = \$ _____ annually to a Health Care Spending Account in 2010. Maximum yearly amount is \$6000.
- I elect not to participate in the Health Care Spending Account in 2010.

Dependent Care Spending Account *(please complete the appropriate spaces):
(This account is for child care expenses only.)

Plan: FSAD

- I elect to contribute \$ _____ per pay period X _____ pay periods = \$ _____ annually to a Dependent Care Spending Account in 2010. Maximum yearly amount is \$5000.
- I elect not to participate in the Dependent Care Spending Account in 2010.

I have read and understand the enrollment materials explaining the Spending Accounts. I understand:

- ◆ any contributions I make to a Health Care Spending Account and/or Dependent Care Spending Account will reduce my taxable income for purposes of Federal Income, State Income and Social Security taxes;
- ◆ the amount I have chosen to contribute for the reimbursement of health care and/or dependent care expenses can be used only for the purposes set forth in the plan description;
- ◆ I cannot change or revoke this agreement during the plan year unless I have a Qualified Status Event Change;
- ◆ any unused funds remaining in my account(s) will be forfeited after April 15th following the end of the plan year.

Date Employee Signature

Date Human Resources Representative

* In order for a medical and/or dependent care expense to be considered a reimbursable "eligible expense" during the 2010 plan year, the medical and/or dependent care services related to that expense must be performed and/or provided within the plan year (January 1, 2010 - December 31, 2010), or in the case of a new employee hired after the start of the plan year, that portion of the plan year in which the employee participates.

DOB _____	DOH _____	DEPT _____	SEX _____	Payroll Start Date _____	PAYS _____
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In signing this form, I understand and agree to the following:

The College and I hereby agree that my cash compensation will be reduced by the amounts I have elected on this form on a per pay period basis during the plan year (during such portion of the year as remains after the date of this agreement).

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE COLLEGE'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

I cannot change or revoke this compensation reduction agreement 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, change in job schedule, lcare provider, 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 my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provision of the Internal Revenue Code.

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

The amount of my compensation reduction during the year will be credited to a medical reimbursement, and/or dependent care assistance account and such amount will be reimbursed for qualified expenses incurred during the year.

My Social Security benefits may be reduced as a result of reduced taxable income due to my election(s).

If required contributions for elected benefits are increased or decreased while this agreement remains in effect, the compensation reduction will automatically be adjusted to reflect that increase or decrease.

Medical Reimbursement will be available only for "qualifying medical care expenses" which are those types of medical expenses normally deductible on your federal income tax return with certain exceptions (i.e. premiums for health insurance can not be reimbursed while over-the-counter medications are allowed). I agree to notify the College if there is reason to believe that any expense for which reimbursement has been obtained is not a qualifying expense. I also agree to indemnify and reimburse the College on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

This agreement will automatically terminate if the Plan is terminated or discontinued.

Dependent Care reimbursement will be available only for "qualifying dependent care expenses" as described below. I agree to notify the College if there is 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 college on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

I agree to provide the Plan Administrator with the name, address, and taxpayer identification number of each dependent care service provider.

Qualifying Dependent Care Expenses:

1. The expenses are incurred for services rendered after the date of this election and during the plan year to which it applies.
2. Each individual for whom I incur the expenses is (A) a dependent under the age 13 who I am entitled to claim as a dependent* on my federal income tax return or (B) a spouse or other tax dependent* who is physically or mentally incapable for caring for himself or herself.
*or a child or other dependent under age 13 who I am supporting but am not entitled to claim as a dependent only because of a written declaration or decree of divorce.
3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable me and my spouse to be gainfully employed.
4. If the expenses are incurred for services outside my household, they are incurred for the care of a dependent who is described in 2(A) above, or who regularly spends at least 8 hours a day in my household.
5. If the expenses are incurred for services provided by a dependent care center (i.e. facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
6. The expenses are not paid or payable to a child of mine who is under age 19 at the end of the year in which the expenses are incurred.
7. The expenses are not paid or payable to an individual for whom me or my spouse is entitled to a personal tax exemption.
8. The reimbursement (when aggregated with all other reimbursements received by you under the Plan during the same year) may not exceed the least of the following limits: (A) The maximum allowed under the Plan. (B) \$5,000 if I am filing a joint tax return or \$2,500 if separate returns are filed. (C) My taxable compensation (after all compensation reduction elections.) (D) If I am married, my spouse's actual or deemed earned income.