



I wish to have my salary redirected for the period 7/1/2011 through 6/30/2012 in each of the categories below. I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of the Coconino Community College Flexible Spending Program.

Social Security Number \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name \_\_\_\_\_  
(Last, First MI)  
Street \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip Code \_\_\_\_\_

Please select the medical plan you are on for FY12:

- Base Plan
- Buy Up Plan
- High Deductible Health Plan

	Per Pay Period	# of Pay Periods	Total for the Plan Year	Not to Exceed
<b><u>General Purpose</u></b>				
Health Care Reimbursement Account	_____	<u>24</u>	_____	\$3,000.00
Dependent Care Assistance Account	_____	<u>24</u>	_____	\$5,000.00
<b><u>*Limited Purpose</u></b>				
Health Care Reimbursement Account	_____	<u>24</u>	_____	\$3,000.00
<b><u>HDHP Plan Participants only</u></b>				
Employer Contribution Only	_____	<u>24</u>	_____	\$ 332.16

\* Combined employer and employee contribution cannot exceed \$3000 for general and limited purpose accounts for participants of HDHP.

**DIRECT DEPOSIT REIMBURSEMENT (Flexible Spending Accounts only)**

I authorize ASI to credit my \_\_\_\_\_ (checking, savings) account number \_\_\_\_\_ at

(name of bank) \_\_\_\_\_, with my Flexible Spending Account payments. Please attach a copy of a check or a void check and write the bank's routing number \_ \_ \_ \_ \_.

**E-MAIL**

\_\_\_\_\_ I wish to receive my notification of direct deposit reimbursement via e-mail over the Internet at the address below instead of U.S. Mail.

E-mail address: \_\_\_\_\_

Employee's signature: \_\_\_\_\_

Date \_\_\_\_\_

