Enrollment Agreement
__2010__ Plan Year

I wish to have my salary redirected for the period ___07/01/09_____through ____6/30/2010______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 County Flexible Spending Program.

Social Security Number _______/______/_________

Name ____ ____
(Last, First MI)

Street ____

City ____
State, Zip

	Per Pay Period	# of Pay Periods	Total for the Plan Year	Not to Exceed
Health Care Reimbursement Account	_________	_24_	_________	$3,000.00
Dependent Care Assistance Account	_________	_24_	_________	$5,000.00

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 ______________

1-800-659-3035
email: asi@asiflex.com
http://www.asiflex.com