



I wish to have my salary redirected for the period 7/1/2009 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 Community College 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
<u>General Purpose</u>				
Health Care Reimbursement Account	_____	<u>24</u>	_____	\$3,000.00
Dependent Care Assistance Account	_____	<u>24</u>	_____	\$5,000.00
<u>*Limited Purpose</u>				
Health Care Reimbursement Account	_____	<u>24</u>	_____	\$3,000.00
<u>HDHP Plan Participants only</u>				
Employer Contribution Only	_____	<u>24</u>	_____	\$ 529.44

* 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 _____