

The Tulalip Tribes  
**MEDICAL FLEXIBLE SPENDING ACCOUNT ELECTION FORM**  
**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT ELECTION FORM**

PLAN YEAR: November 1, 2008 - October 31, 2009

(PLEASE PRINT)

**1. PERSONAL DATA**

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Email Address: \_\_\_\_\_

**DEPENDENT INFORMATION (Must list all dependents affected by enrollment)**

LAST NAME	FIRST NAME	RELATIONSHIP	M/F	DATE OF BIRTH
Employee		<i>Self</i>		
Dependent				

PAYROLL DEDUCTION SCHEDULE: Semi-monthly

PAY SCHEDULE: Semi-monthly

**2. FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS**

Medical Flexible Spending Account     YES     NO    \$ \_\_\_\_\_ Annually / \$ \_\_\_\_\_ Per Pay Period  
(\$3000.00 per year maximum)

Dependent Care Flexible Spending Acct     YES     NO    \$ \_\_\_\_\_ Annually / \$ \_\_\_\_\_ Per Pay Period  
(\$5000.00 per year maximum)

**3. AUTHORIZATION AND ACKNOWLEDGEMENT**

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Change in Family Status". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized receipts) for out-of-pocket Medical, Dental, Vision expenses before I can be reimbursed.

I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize The Tulalip Tribes to make pre-tax deductions from my salary on the payroll schedule I've elected above. I understand that to stop such deductions, I must notify (and provide proof of the qualifying event) The Tulalip Tribes's Human Resources and/or Payroll Department in writing with my request and revoke this authorization.

Any unused dollars remaining in your Flexible Spending Account at the end of the year will be forfeited. Expenses/claims must be incurred during the time that you participate in the plan in order to be eligible for reimbursement.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_