

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

PLAN YEAR: November 1, 2010 - October 31, 2011

(PLEASE PRINT)

1. PERSONAL DATA

Name: _____ Phone # _____

Address _____

Soc. Sec. # _____ Date of Birth: _____ Date of Hire: _____

Email Address: _____ Department: _____

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 (**Per Family**) Single Married (If married, list spouse's annual election: \$ _____)

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 Benefits 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.

4. Please return this form to Peoples Benefit Solutions or your Benefit Administrator.

SIGNATURE _____ DATE _____

Name	Phone	Fax	E-mail
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