

624 Grassmere Park Drive, Suite 15
Nashville, TN 37211
Fax (615) 831-9910 (800)-449-7501

YOUR E-MAIL: _____

Plan Year _____ through _____

Employer _____ Telephone _____

Employer Address _____

(City) (State) (Zip)

EMPLOYEE: _____
(First Name) (MI) (Last Name)

Social Security Number _____ Home Phone Number: _____

Address: _____

(City) (State) (Zip)

DEPENDENT CARE SPENDING ACCOUNT Yes, I elect to participate

Day Care Provider Name Day Care Provider Phone Day Care Provider Social Security

Day Care Provider Address, City, State, Zip Code

FIRST Dependent Name Dependent Birth Date Day Care Cost \$ _____ Direct Pay
Pay Weekly Pay Monthly Reimbursement

Day Care Provider Name Day Care Provider Phone Day Care Provider Social Security

Day Care Provider Address, City, State, Zip Code

SECOND Dependent Name Dependent Birth Date Day Care Cost \$ _____ Direct Pay
Pay Weekly Pay Monthly Reimbursement

I AM PAID (check box below) AND HAVE CHOSEN TO REDIRECT PRE-TAX MONEY IN THE AMOUNT OF:

Weekly: \$ _____ Bi-Weekly: \$ _____ Semi-Monthly: \$ _____ Monthly: \$ _____

Total Yearly Pre-Tax Deduction: \$ _____ If my employer allows post-tax deductions I elect: \$ _____ per pay period

As an eligible employee, I understand a copy of the Summary Plan Description is available at my place of employment and understand the benefits, rights and obligations included in the plan. I understand that dependent care payments will be made on my behalf only for "QUALIFIED" expenses as described in the Summary Plan Description and more fully outlined in Section 129 of the IRS Code. I agree to contact my employer for clarification if I have any reason to believe that I have received a benefit for any expenses that do not qualify. I understand that dependent care payments made on my behalf will not be more than the amount in my dependent care account at that time and that any amount not used during the plan year will be surrendered to the Benefit Plan Surplus and disposed of as outlined in the Summary Plan Description. I understand that, in the event of my death, any benefit due will be paid to my estate. I understand this redirection may have a minimal effect on my Social Security benefits and that I cannot claim the child care credit on any amount redirected through this program. I understand that, except for certain family status situations as defined in the Summary Plan Description, my participation in this plan is for the entire plan year. If I chose reimbursement, I understand that I must submit signed provider receipts prior to reimbursement and that this could cause a delay in reimbursement. Prior to the beginning of each plan year, I will be given an opportunity to change the amount of my redirection or revoke my participation. If I do not submit a new election, the prior year's election will remain in effect for the new plan year.

SIGNED _____ DATE _____