Torchmark Corporation Affiliates

Effective January 1, 2011

2011 Open Enrollment
Employee Benefits

WHO TO CONTACT?

Need more information than this or the *Employee Benefit Guide for 2011* can provide? Please see one of your Human Resources professionals for answers to your questions.

Benefit Questions:

Pam Ali
Human Resource Specialist
254.761.6630
pfali@ailife.com

Annual Benefit Enrollment is here!

Don't miss this opportunity to enroll in or make changes to your benefits.

Enrolling in Benefits

You may enroll in benefits as a new hire and during the annual enrollment period each year.

As you make your enrollment decisions for the coming year, keep the following points in mind:

- You cannot change your benefits during the year, unless you have a qualified family status change. For more information about qualified family status changes, see the Employee Benefit Guide for 2011.
- If you have been previously treated or diagnosed with a medical condition, you may be subject to a 12-month pre-existing condition exclusion. This exclusion may be reduced or waived depending on the length of previous creditable coverage.

Here are important dates to remember:

- **December 6, 2010 –** Annual Benefits enrollment ends at 4 PM CST for all employees.
- **January 1, 2011 –** Your 2011 benefit elections take effect and remain in effect until December 31, 2011.

Do you need to enroll?

You need to enroll if:

You wish to change your current coverage in any of the following benefits:

- Medical
- High Deductible Health Savings Account – *NEW!*
- Vision – *NEW!*
- Dental
- Flexible Spending Account

Before you enroll…

- Read the information in this packet to learn what's new for 2011.
- For more details about all of your benefit choices, see the *Employee Benefit Guide for 2011*.

Ready to enroll?

Complete the 2011 Open Enrollment Election form and return to your local Human Resources department. If you are newly enrolling, making changes or cancelling coverage, you must complete the appropriate forms. The list of forms is located on page 3 of this guide.

New for 2011

BlueCross BlueShield Medical Plan

Medical coverage is offered by BCBS and comes in a choice of three plans: Base, Mid and High. Deductibles, copayments, and coinsurance have changed for all three BCBS medical plans. The Base plan now has a $400 Individual deductible, Mid plan has a $600 Individual deductible, and High plan has a $1,200 Individual deductible.

- Dependents up to age 26 are now eligible for coverage.
- Prescriptions covered for smoking cessation drugs.

If you would like to change plans, you may do so now. Once a plan is selected you cannot change until the following open enrollment period.

The 2011 medical rates are located on page 3 of this guide. The BCBS website for members is *www.bcbstx.com/torchmark*.

High Deductible Health Savings Account *(HSA)*

A pre-tax Health Savings Account or HSA is offered to those who enroll in the BCBS High Deductible Medical Plan.

- It allows you to pay for many of the health care expenses not covered by your Medical Plan including deductibles and copayments.
- This account is managed by Wells Fargo.
- You may contribute up to $3,050 for individual coverage or $6,150 for family coverage per calendar year.
- You may change the amount of your contribution at any time throughout the year and you can choose the amount of contribution cycles you would like to have the deduction taken out of.
- At age 55, you may contribute an additional $1,000.
- There is a monthly administration fee of $3.75.

There is no "use it or lose it" rule for the HSA account. At the end of the year, your balance carries over. Also, even if you change jobs, you control the funds in your HSA and decide when and how you want to use them. You also have 24/7 online access to your account and can manage your account online anywhere with Internet access.

DAVIS**VISION** Vision Plan

Davis Vision will offer a separate vision plan that can be elected with or without medical coverage. The coverage includes a $10 exam copayment, $25 spectacle lenses copayment, and $25 contact lens evaluation, fitting, and follow-up care copayment. There are over 30,000 providers in their network.

The 2011 vision plan rates are located on page 3 of this guide.

MetLife® Dental Plan

MetLife® continues to offer Torchmark Corporation Affilitates with dental coverage. MetLife offers two plans: Full and Basic. Here is what has changed for 2011:

- Premium no longer deducted in advance.
- Bitewing X-Rays changed to 1 per 24 months.
- Amalgams *(fillings)* changed to 1 per 24 months per tooth.
- Root Canal changed to 1 per lifetime per tooth.
- Replacement crowns, inlay & onlay, partial & complete dentures; post & cores, veneers, stainless steel crowns, Implants, Bridges changed to 1 in 7 years.

The 2011 dental rates are located on page 3 of this guide.

Flexible Spending Accounts *(FSA)*

An FSA account cannot be used for medical expenses if you are enrolled in the HSA account. Over the counter medications can no longer be reimbursed unless a prescription is written.

The 2011 maximum annual amount for medical reimbursement is $6,000. The 2011 maximum annual amount for dependent reimbursement is $5,000 or $2,500 if married and filing separate tax returns. To enroll in the flexible spending accounts, continue your current contribution or change your contribution amount, remember to carefully estimate your anticipated expenses for 2011. For more information see the 2011 Employee Benefits Guide.

2011 Premiums

You pay for benefits through convenient payroll deductions. Medical, dental, vision, flexible spending account, and health savings account deductions are all pre-taxed.

Medical Insurance Rates

When it comes to health care, you and the Company share the cost of coverage. The following chart lists your semi-monthly costs. These rates do not include the additional premiums for tobacco use, spousal coverage and the HRA exam.

BASE PLAN	Semi-Monthly Rate
Employee *(All Ages)*	$48.00
Spouse *(All Ages)*	$140.50
Per Dependent Child *(max 2)*	$53.50

MID PLAN	Semi-Monthly Rate
Employee *(All Ages)*	$34.50
Spouse *(All Ages)*	$99.50
Per Dependent Child *(max 2)*	$38.50

HIGH PLAN	Semi-Monthly Rate
Employee *(All Ages)*	$30.00
Spouse *(All Ages)*	$85.50
Per Dependent Child *(max 2)*	$33.00

Vision Insurance Rates

	Semi-Monthly Rate
Employee Only	$2.72
Employee + Spouse	$4.89
Employee + Child*(ren)*	$5.16
Employee + Family	$8.15

Dental Insurance Rates

Plan A (Full) Coverage	Semi-Monthly Rate
Employee Only	$15.71
Employee Plus One	$32.03
Employee Plus Two or more	$53.45

Plan B (Basic) Coverage	Semi-Monthly Rate
Employee Only	$11.54
Employee Plus One	$21.71
Employee Plus Two or more	$36.39

Open Enrollment Forms

- 2011 Open Enrollment Election Form
- BCBS Medical Enrollment Form
- Wells Fargo Health Savings Account *(HSA)* Authorization Form
- MetLife® Dental Enrollment Form
- Davis Vision Enrollment Application
- Flexible Spending Account *(FSA)* Enrollment Form

Complete and Return These Forms:

To make No Change in coverage:

	◦ 2011 Open Enrollment Election Form

To Enroll or Change coverage:

All	◦ 2011 Open Enrollment Election Form
Medical	◦ BCBS Medical Enrollment Form
HSA	◦ Wells Fargo HSA Authorization Form
Dental	◦ MetLife® Dental Enrollment Form
Vision	◦ Davis Vision Enrollment Application
FSA	◦ FSA Enrollment Form

Where are the forms?

All forms are in this packet or you can download them at *www.tmkemployeebenefits.com*.

2011 OPEN ENROLLMENT ELECTION FORM

RETURN THIS AND ALL APPLICABLE FORMS TO THE HUMAN RESOURCES OFFICE BEFORE DECEMBER 6, 2010

EMPLOYEE INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #

Address, Street	City	State	ZIP

Phone, Home	Alternate ○ Cell ○ Work	E-mail Address

○ HOURLY ○ SALARY | Company ○ Globe ○ GMS ○ LNL ○ UA

If no change is indicated, your benefits will remain the same as 2010, except for the Flexible Spending Accounts *(FSA)*. FSA participants must re-enroll each year.

○ I WANT **NO** CHANGE TO MY BENEFITS FOR THE 2011 CALENDAR YEAR.

Mark the appropriate change to the specific benefit below:

BlueCross BlueShield (BCBS) Medical Plan — Medical Insurance

○ No Change ○ Add Dependent ○ Enroll In:
○ Cancel All ○ Delete Dependent ○ Change Plan To:

○ Base Plan *($400 Deductible)*
○ Mid Plan *($600 Deductible)*
○ High Plan *($1,200 Deductible)*

NOTE: If you are newly enrolling, making changes, or cancelling, you must complete the Medical Enrollment Form and the Torchmark Medical Affidavit

Wells Fargo HSA — High Deductible Health Savings Account *(available with BCBS High Plan only)*

○ Enroll ○ Decline

NOTE: Only available with BlueCross BlueShield High Plan *($1,200 deductible)*. You must complete the Wells Fargo Enrollment Form

MetLife® Dental Plan

○ No Change ○ Add Dependent ○ Enroll:
○ Cancel All ○ Delete Dependent ○ Change Plan To:

○ Plan A *(Full)*
○ Plan B *(Basic)*

NOTE: If you are newly enrolling, making changes, or cancelling, you must complete the MetLife® Dental Enrollment • Change Form

DAVISVISION — Vision Plan

○ Enroll ○ Decline

NOTE: If you are newly enrolling, you must complete the Davis Vision Enrollment Application

Flexible Spending Accounts (FSA)

○ Enroll
○ Decline

○ Medical ○ Dependent Care ○ Transportation

NOTE: To continue, change, or enroll, you must complete the FSA Enrollment Form

I authorize deductions to be made from my paychecks for the above selected benefits.

Print Name _____ Signature _____ Date _____

MEDICAL PLAN ENROLLMENT FORM

EMPLOYEE INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #

Address, Street	City	State	ZIP

Phone, Home	Alternate ○ Cell ○ Work	E-mail Address

BlueCross BlueShield (BCBS) Medical Plan — Medical Insurance

○ **Enroll** ○ **Change Plan** ○ **Add Dependent** ○ **Delete Dependent** ○ **Cancel All**

I elect the following Medical coverage: *(select one)*

○ **Base Plan** *($400 Deductible)* ○ **Mid Plan** *($600 Deductible)* ○ **High Plan** *($1,200 Deductible)*

○ Employee Only ○ Employee and ____ Child*(ren)* ○ Employee and Family, ____ Child*(ren)* ○ Employee and Spouse

Spouse Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*

Coverage ○ Add ○ Delete	Sex ○ Male ○ Female	Relationship ○ Husband ○ Wife	

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*

Coverage ○ Add ○ Delete	Sex ○ Male ○ Female	Relationship ○ Son ○ Daughter	

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*

Coverage ○ Add ○ Delete	Sex ○ Male ○ Female	Relationship ○ Son ○ Daughter	

MEDICAL PLAN ENROLLMENT FORM

Previous Health Coverage Information — *MUST COMPLETE THIS SECTION IF NEWLY ENROLLING*

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this enrollment application. If more than one plan was in effect, or if information is different for dependents, attach additional pages.

List names of every individual covered:

Primary Enrollee Name, Last	**First**	**MI**	**Sex** ○ **Male** ○ **Female**	**Date of Birth** *(mm/dd/yyyy)*
Relationship to Applicant ○ **Self** ○ **Spouse** ○ **Dependent**	**Employer Name**		**ID Number**	**Group or Policy Number**

Name and Address of other insurance company, TPA, HMO	**Employment Information**	**Type of Policy**	**Type of Coverage**
	Employment Date _____ Effective Date _____ Will Coverage be Continued? ○ Yes ○ No If No, Expected Cancellation Date _____	○ Employer Sponsored ○ Individual Purchase	○ Self ○ Family ○ Employee / Spouse ○ Employee / Child

ACKNOWLEDGEMENT

This will certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected coverage or declined coverage as indicated. If I desire to apply for coverage at a later time, I understand that there may be a delay in the effective date of coverage as well as a pre-existing condition waiting period. I authorize necessary payroll deductions by my Employer to cover the cost of my coverage(s) and that these deductions will remain in effect for the duration of the plan year. I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.

Print Name _____ Signature _____ Date _____

2011 HEALTH SAVINGS ACCOUNT ENROLLMENT FORM

WELLS FARGO HEALTH SAVINGS ACCOUNT (HSA)

EMPLOYEE IDENTIFYING INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #
Address, Street	City		State	ZIP
Phone, Home	Alternate ○ Cell ○ Work		E-mail Address	
Country of Citizenship			Date of Birth *(mm/dd/yyyy)*	

Residency Status ○ **U.S. Citizen** ○ **Permanent/Resident Alien** ○ **Non-Permanent/Non-Resident Alien**

HEALTH SAVINGS ACCOUNT (HSA) ELECTION — *BCBS High Deductible Health Plan ONLY*

Employee Annual Election $

To be contributed in (select one)

○ **Single Annual** installment
○ **Each Pay Period** installments
○ _____ installments (maximum 24)

Please note that the sum of the Employee Annual Election cannot exceed the IRS' mandate of $3,050 for an individual / $6,150 for a family.

○ **$** _____ **Catch-up contribution for Ages 55 and above** *(Deducted per pay period; Maximum contribution $1,000)*

_____
(Please initial)

I understand that I will be subject to $3.75 monthly maintenance fee that will be charged to my HSA account.

WELLS FARGO

Please fill out, sign and return this form to your Employer.
Do not send this form to Wells Fargo Health Benefit Services

Enrollment Election

I want to establish a Health Savings Account *("HSA")* at Wells Fargo Bank, N.A. *("Wells Fargo")*. I certify that I am eligible to contribute to an HSA under Internal Revenue Code Section 223. I understand that I may access the agreements governing my HSA via the Wells Fargo Health Account Manger℠ web portal online at *https://healthbenefits.wellsfargo.com/hbs* or by calling 866-884-7374. I further understand that a copy of the agreements governing my HSA will be sent to me in a "welcome packet" after my HSA is opened and that I will have seven *(7)* business days to revoke my HSA after the welcome packet is sent.

Appointment of Employer as Special Agent for Account Opening Purposes

By signing in below, I appoint Torchmark Corporation *("Employer")* as my special agent for purposes of opening a Wells Fargo HSA.

As my special agent, Employer will receive a notice from Wells Fargo on my behalf, which explains that, consistent with its efforts to help the government of the United States fight money laundering activities and terrorism funding, Wells Fargo obtains, verifies, and records information to identify each individual who opens a Wells Fargo HSA. I hereby provide the Identifying Information listed above to Employer and authorize Employer to forward this information to Wells Fargo on my behalf in furtherance of my establishing a Wells Fargo HSA.

I agree that Employer will be my special agent unless and until the earlier of the following three events occurs: *(i)* I submit written notice to Employer that I intend to terminate this appointment, and Employer has a reasonable period of time to act on such notice; *(ii)* I receive my HSA "welcome packet" from Wells Fargo; or *(iii)* I receive a notice from Wells Fargo that my application for an HSA has been declined.

Signature of Employee

By signing below, I agree to the above. I also authorize Wells Fargo to make any inquiries that it considers appropriate to determine if it should open and maintain my HSA. This may include ordering my credit *(or other)* report *(e.g. information from any motor vehicle department or other state agency)*.

Print Name _____ Signature _____ Date _____

MetLife
Metropolitan Life Insurance Company, New York, NY

DENTAL ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Torchmark Corporation	**104282**	**104282**		
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			
Original COBRA Effective Date if applicable (MM/DD/YYYY)	COBRA Termination Date if applicable (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)		Social Security #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

Dental Insurance

Select your level of coverage

- ☐ Employee Only
- ☐ Employee + One Dependent (Spouse or Child)
- ☐ Employee + Two or More Dependents (Spouse and Children)

Select your plan type

- ☐ Plan A (Full)
- ☐ Plan B (Basic)

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last) / Date of Birth (MM/DD/YYYY)

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

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SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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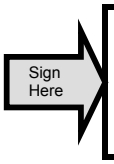
DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.



Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

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DEC

DAVISVISION ENROLLMENT APPLICATION

SUBSCRIBER INFORMATION *(PLEASE PRINT)*

Name, Last	First	MI	Social Security No.	Employee ID #
Address, Street	City		State	ZIP
Phone, Home	Alternate ○ Cell ○ Work		E-mail Address	

Reason for Application ○ Addition ○ Change ○ Reinstate ○ COBRA ○ Termination ○ Waive Coverage

Type of Coverage ○ Subscriber Only ○ Subscriber and Spouse ○ Family ○ Subscriber and Child ○ Subscriber and Children

DAVIS**VISION — TYPE OF COVERAGE**

Subscriber Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
Self	○ Add ○ Terminate	○ Male ○ Female	○ Student Over 19 ○ Disabled	

Spouse Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Spouse	○ Add ○ Terminate	○ Male ○ Female	○ Student Over 19 ○ Disabled	

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Child ○ Other	○ Add ○ Terminate	○ Male ○ Female	○ Student Over 19 ○ Disabled	

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Child ○ Other	○ Add ○ Terminate	○ Male ○ Female	○ Student Over 19 ○ Disabled	

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Child ○ Other	○ Add ○ Terminate	○ Male ○ Female	○ Student Over 19 ○ Disabled	

Dependent Name, Last	First	MI	Social Security No.	Date of Birth *(mm/dd/yyyy)*
○ Child ○ Other	○ Add ○ Terminate	○ Male ○ Female	○ Student Over 19 ○ Disabled	

ACKNOWLEDGEMENT

"I certify that this enrollment information is true and correct."

Print Name ____________________ Signature ____________________ Date ____________

2011 FLEXIBLE SPENDING ACCOUNTS ENROLLMENT FORM

EMPLOYEE INFORMATION

Name, Last	First	MI	Social Security No.	Employee ID #
Address, Street	**City**		**State**	**ZIP**
Phone, Home	**Alternate** ◯ **Cell** ◯ **Work**		**E-mail Address**	

Write in the annual amount you wish to contribute to your Flexible Spending Account for 2011.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Health Care Spending Account *($6,000 Maximum)*	**$**
Dependent Care Spending Account *($5,000 Maximum or $2,500 maximum if married and filing a separate tax return)*	**$**
If you are married and plan to open a Dependent Care Spending Account, please indicate whether you are planning to file a joint or separate income tax return this year.	◯ **File Joint** ◯ **File Separate**
Transportation Spending Account *(You can contribute the monthly rate charged for parking up to $230, and up to $230 per month for mass transit)*	**$**

An FSA account cannot be used for medical expenses if you are enrolled in the HSA account, but can be used for vision and dental expenses.

ACKNOWLEDGEMENT

I authorize the reduction of my gross earnings by the amount designated above. I wish to have this amount deducted in equal amounts over 24 pay periods.

I understand that amounts deducted from my pay and not used for eligible health care or dependent care expenses incurred during the period of coverage, will be forfeited in accordance with IRS regulations.

I also understand that this authorization is irrevocable until the next election period unless I have a change in family status (i.e., marriage, divorce, death of spouse, birth or adoption, termination of employment, unpaid leave of absence of employee or spouse, or any significant change in spouse's employment, hours or health coverage because of spouse's employment.)

Print Name _____ Signature _____ Date _____