MEDICAL COLLEGE OF GEORGIA

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

☐ Dependent Care ☐ Health Care ☐ Both

PLAN YEAR JANUARY 1, 2007 - DECEMBER 31, 2007

RE-ENROLLMENT IS REQUIRED FOR EACH PLAN YEAR

Employee Name: Last First MI	Address, City, State and Zip:
Employee ID Number: (leave blank if unknown)	Department Name:
Contact Number:	Effective Date:

By my signature below, I authorize the Medical College of Georgia to reduce my monthly or biweekly paycheck(s) in the amount designated below, and to deposit that amount in my Dependent Care and/or Health Care Flexible Spending Account. **I understand that I can change this election only during the designated Benefits Open Enrollment period, and any changes made will become effective on January 1, 2007 except in the event of one or more of the qualifying changes in family circumstances allowed by law, in which case the changes I elect must be consistent with the family status change.** I understand that if I should terminate my employment, all deposits to the spending account will cease effective the date of my termination, and I may continue to submit claims to the Dependent Care and/or Health Care Flexible Spending Account until the balance of the account has been depleted or the end of the current plan year, whichever comes first. I understand that if I utilize the MCG Child Care Center that the charges for child care services **will not** be automatically deducted from my Dependent Care Flexible Spending Account.
I also understand that I must adhere to IRS regulations for reimbursement from my FSA. The maximum contributions for the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account for Calendar year 2007 is $5,000.00 for each account.

Signature: ______________________________ Date: ______________

*Plan documents may be obtained by visiting http://www.mcg.edu/hrforms/pdf/FlexibleSpendPlan.pdf or contacting the Benefits Staff at (706) 721-3770.

Dependent Care

Pay Category	Amt to be Deducted Per Pay Period		Number of Paychecks		Total Annual Goal Amount
________Academic	____________	X	________ (10)	=	________
________Monthly	____________	X	________ (12)	=	________
________Bi-Weekly	____________	X	________ (26)	=	________

Health Care

Pay Category	Amt to be Deducted Per Pay Period		Number of Paychecks		Total Annual Goal Amount
________Academic	____________	X	________ (10)	=	________
________Monthly	____________	X	________ (12)	=	________
________Bi-Weekly	____________	X	________ (26)	=	________

__________ Date

__________ Benefits Staff