

Gwynedd Mercy College

CAFETERIA PLAN ELECTION FORM FOR THE 2010 PLAN YEAR

This election form is used to elect to participate in the Cafeteria Plan for the period starting on January 1, 2010, and ending December 31, 2010.

Employee Information:

Name: (First) (MI) (Last)	Social Security No:
Address: (Street) (City) (State) (Zip)	

Part One: Insurance Contributions

The first part of your Cafeteria Plan involves the insurance premiums you currently pay through your employer via payroll deduction. These premiums can be for Health, Dental, Vision, or any other Insurance Plans deemed eligible by the Internal Revenue Service that your employer offers. These Plans must be sponsored by your employer to be eligible for the pre-tax benefit through your Cafeteria Plan. Individually owned policies or policies sponsored by your spouse's employer are **not** eligible through this Plan. Please indicate your election by checking the appropriate box below:

Please check one:

[]	Yes, I want to save taxes! Please deduct the portion I pay towards my insurance before applicable taxes are calculated on my income!
[]	No, I do not wish to save taxes on this expense. Please deduct my insurance contribution after applicable taxes are calculated on my income.

Part Two: Flexible Spending Accounts (FSA):

The second part of your Cafeteria Plan consists of the Health Care Reimbursement and Dependent Day Care Reimbursement accounts also referred to as Flexible Spending Accounts. Please refer to our brochure entitled "Keep More of What You Earn" for further explanation of these accounts including a worksheet of eligible expenses to help you calculate your annual election. If you find that you could benefit from one or both of these accounts, please make your election below. Be sure your elections do not exceed the Plan Maximums and do not include any insurance premiums in your election for the Health FSA.

FLEXIBLE SPENDING ACCOUNT	PRE-TAX AMOUNT PLAN YEAR	PRE-TAX AMOUNT PER PAY	PLAN YEAR MAXIMUMS
Health Care Reimbursement <small>(UNINSURED MEDICAL, DENTAL, & VISION EXPENSES)</small>	\$	\$	\$3,000
Dependent Day Care* <small>*Please call our office if your spouse does not have earned income</small>	\$	\$	\$5,000

Waiver of FSA Coverage (please check):

[]	I do not wish to participate in a Flexible Spending Account.
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I acknowledge that:

- I have voluntarily elected to participate or not participate in the Plan for the benefits listed above and authorize my employer to reduce my salary in the amount necessary for the coverages elected.
- Any amount placed in a Flexible Spending account may not be used for another benefit.
- All administrative requirements for verifying reimbursement claims (such as proper claim filing and submitting proper documentation) must be satisfied before I am entitled to receive reimbursements.
- I will forfeit any funds left in my FSA if I fail to incur or properly verify a reimbursable expense.

_____ Employee Signature	_____ Date
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