

Adelphi University
Enrollment Form for Health Care Spending Account

Plan Year: January 1 to December 31, 2009

Employee Information

Name _____ Social Security # _____
(please print)

Address _____

City _____ State _____ ZIP _____

Daytime Phone Number _____

Health Care Spending Account Election

Please indicate the amount of your salary you wish to contribute to the Health Care Spending Account.

Number of pay periods	x	Contribution per pay period	=	Total annual contribution
_____	x	\$ _____	=	\$ _____
26		(\$ 7.69 min., \$ 192.30 max.)		(\$200.00 min., \$5,000.00 max.)
12		(\$16.66 min., \$416.66 max.)		

Authorization

Please read the statement below, then sign and date this form.

This form must be completed and returned to the Office of Human Resources by December 1, 2008 to be effective for January 1, 2009.

I authorize the redirection of my salary (on a per paycheck basis) for contributions to my Health Care Spending Account. I understand that such redirections will be made on a pre-tax basis.

I understand that amounts redirected from my pay and not used for health care expenses incurred during the Plan year will be **forfeited** in accordance with Internal Revenue Service regulations. I also understand that this authorization is irrevocable until the next Plan year unless I have a change in family status (i.e., marriage, divorce, birth or adoption of a child, termination of spouse's employment or health insurance, etc.).

SIGNATURE _____ DATE _____