

**FERRUM COLLEGE
SECTION 125 CAFETERIA PLAN
FLEXIBLE BENEFIT PLAN
SALARY ADJUSTMENT AFFIDAVIT
APRIL 1, 2006 TO MARCH 31, 2007**

DEDUCTION EFFECTIVE _____

I, _____, SSN _____ - _____ - _____
(Please Print)

* _____
Mailing Address (including city, state, and zip code)

Personal Email Address _____ Work Phone # _____ Home Phone # _____

an employee of the employer noted above, do hereby elect to participate in my employer's Flexible Benefit Plan and to be reimbursed for the expenditures indicated below, all of which I will incur during the above Plan Year. Each of the declared amounts indicated below are reimbursements and satisfy the requirements under the Flexible Benefit Plan as described in the employer Plan Document.

I hereby authorize my employer to reduce my gross compensation each **SEMI-MONTHLY** or **MONTHLY** pay period by an amount equal to the total of these expenditures.
(24) (12)
PLEASE CIRCLY YOUR PAY CYCLE

	<u>Per Pay Period</u>	<u>Annual Election</u>
HEALTH CARE REIMBURSEMENT ACCOUNT (Qualified unreimbursed health care expenses)	\$ _____	\$ _____
Max. Annual Election: \$4,000.00		
Min. Annual Election: \$120.00		
DEPENDENT CARE REIMBURSEMENT ACCOUNT (Qualified child care and dependent care expenses)	\$ _____	\$ _____
Max. Annual Election: \$5,000.00		
Min. Annual Election: \$120.00		
TOTAL	\$ _____	\$ _____

Treatment of Unused Declarations

If, at the end of the Plan Year, the total of my declared reduction in compensation exceeds my substantiated incurred expenses, I recognize that the difference in the amounts will be forfeited. I further acknowledge that the above listed amounts shall be irrevocable until the beginning of the next Plan Year unless there is a material change in my family situation of a nature permitting a mid-year change under IRS regulations.

- I am a **New Participant** and I elect to be issued an **MBI Benefits CardTM**.
- I am a **Renewing Participant** and I elect to **CONTINUE** using my previously-issued **MBI Benefits CardTM**.
- I am a **Renewing Participant** and my card has been **lost / destroyed**. Please re-issue me a new **MBI Benefits CardTM**.
- Please issue an additional card for the dependent listed below:

<i>Dependent Name</i>	<i>Dependent Social Security Number</i>
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MBI Benefits CardTM CERTIFICATION

I acknowledge that I will agree to the terms and conditions of the Cardholder Agreement received with my **MBI Benefits CardTM** and certify that I will only use the card for qualified health care and/or dependent care expenses. I further certify that I will not seek reimbursement under any other health plan coverage for claims that have been paid for by the card, nor will I use the card for expenses that have been paid by any other health plan benefit. I acknowledge that I will, upon request of the plan administrator, provide required documentation of expenses.

I hereby certify that I have examined this Salary Adjustment Enrollment Form and to the best of my knowledge and belief, it is true, correct, and complete.

DATE

WITNESS

SIGNATURE

* **Please notify Flexible Benefit Administrators, Inc. if you have a change of address.**
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