Debit Card ☐Yes ☐ No Limited Purpose ☐Yes

Combined Services LLC
EMPLOYEE BENEFITS

BENNINGTON COLLEGE

ENROLLMENT FORM
Employee Reimbursement Account

EMPLOYEE INFORMATION (Please print)

Name	Social Security Number	Date of Hire	Date of Birth
Mailing Address	City	State	Zip

Home Phone Number ( )	Work Phone Number ( )	Dept.	*Email Address

*If you provide an email address, Combined Services LLC will contact you at that address regarding your account.

DEPENDENT INFORMATION

Name	Social Security Number	Date of Birth	Relationship

INSTRUCTIONS

1. Complete the Employee and Dependent Information sections above. If additional space is needed, please attach a separate sheet of paper.
2. Read the Employee Reimbursement Accounting Agreement below. Fill in the amount of the contributions that you wish to make to the Employee Reimbursement Account during the plan year.
3. Sign and date the form and return it to your supervisor or Personnel Department.

EMPLOYEE REIMBURSEMENT ACCOUNT

I agree to have my gross salary reduced, in accordance with section 125 of the Internal Revenue Code, to contribute to the Employee Reimbursement Account in the amount indicated below.

I instruct my employer to make these contributions on my behalf. This salary reduction arrangement will continue until:

- I terminate employment with my present employer; or
- I have a change in family status (e.g. marriage, divorce, birth or adoption of a child, death of a spouse or dependent, or change in my or my spouse's employment status) that makes it necessary for me to modify this agreement: or
- The end of the plan year covered by this agreement. For future plan years, I will have the opportunity to modify this agreement; or
- My employer terminates, suspends, or modifies this plan.

I understand that if I do not return this form to my employer, they will assume I do not want to participate in the Employee Reimbursement Account program.

I understand that if my participation should end due to a qualifying event, prior to the plan year's end, I am able to submit eligible claims to my Employee Reimbursement Account that were incurred prior to the end date of my participation.

I understand that contributions to the Employee Reimbursement Account can only be reimbursed to me for eligible expenses within each plan. (For example, funds in the Medical Reimbursement Plan cannot be used for reimbursement of dependent care expenses.) I further understand that if I do not use the funds in my Employee Reimbursement Account during the plan year, those funds will not be paid to me; they will be forfeited. However, I do realize that I have 90 days after the plan year's end to submit claims for expenses incurred during that plan year. I also understand that reimbursement expenses cannot be claimed as credits or deductions on my personal tax return.

EMPLOYEE AUTHORIZATION – SHADED AREA TO BE COMPLETED BY EMPLOYER

I have read and understood the above agreement. I authorize the following contributions to my Employee Reimbursement Account during the plan year:

- Medical Reimbursement Plan $_____ annually ÷ _____ # pay period = _____ $ pay period
- Dependent Care Reimbursement Plan ($5,000 maximum or $2,500 if married filing separately) $_____ annually ÷ _____ # pay period = _____ $ pay period

In the event our group does not pass the necessary nondiscrimination tests, I authorize my employer to make any necessary reductions to my election in order to conform with the nondiscrimination rules.

The salary reduction will begin with the payroll dated _____ and continue through _____

_____ Employee Signature _____ Date

I choose not to participate. _____ Employee Signature _____ Date