



FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

WORK-SITE LOCATION: _____

EMPLOYEE:

Last Name First Name M.I.

Address Apt. #

City State Zip

Home Telephone Social Security Number

HEALTH CARE FLEXIBLE SPENDING ACCOUNT:

Yes, I elect to participate in the Health Care Flexible Spending Account for this plan year.

\$ _____ / Annually *Maximum deduction per plan year is \$5,000.

I hereby authorize CoStaff Services to reduce my compensation by the amount set forth above, in installments for each pay period. I understand that the amount of my compensation reduction or each pay period will be credited to this elected benefit for the year on the books of the company, and I will be reimbursed up to the balance in the account of my qualifying medical expenses. I also understand that if I do not use the funds set aside for the elected benefits, the money will be forfeited.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT:

Yes, I elect to participate in the Dependent Care Flexible Spending Account for this plan year. I understand that an eligible tax-dependent child (including adopted children, stepchildren and foster children) must be under age 13.

\$ _____ / Annually *Maximum deduction per plan year is \$5,000.

If the amount I have elected exceeds \$2,500 for the plan year, I hereby certify that:

I will file a joint federal income tax return with my spouse for the year; or

I am NOT married.

I hereby authorize CoStaff Services to reduce my compensation by the amount set forth above, in equal installments for each pay period. I understand that the amount of my compensation reduction for each pay period will be credited to this elected benefit for the year on the books of the company, and I will be reimbursed up to the balance in the account of my qualifying dependent care expense. I also understand that if I do not use the funds set aside for the elected benefits, the money will be forfeited.

Employee Signature

Date

I hereby certify that I understand that I cannot change or revoke this compensation reduction agreement at any time during the plan year without a qualified status change event; and the plan administrator may reduce or cancel my compensation reduction, limit my reimbursements, or otherwise modify this agreement in the event the administrator believes it is advisable in order to satisfy provisions of the Internal Revenue Code.