

THURSTON COUNTY
FLEXIBLE SPENDING ACCOUNTS
ENROLLMENT FORM & SALARY REDIRECTION AGREEMENT

EMPLOYEE I.D. NUMBER: _____ WORK LOCATION _____

NAME _____ SOCIAL SECURITY NUMBER: _____

ADDRESS _____ PHONE # _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL ADDRESS _____ DATE OF BIRTH _____

LIST TAX DEPENDENTS ELIGIBLE FOR BENEFITS: _____

This agreement is made as of _____ between Thurston County, hereinafter
(first day of Plan Year)
called Employer and _____, hereinafter called Employee.
(Employee Name)

This Agreement intends to conform with Sec (s). 79, 105, 106, 125, 129 of the I.R.S. Code providing employee benefits. As provided for in said Sections, Employer has created a Cafeteria Plan to provide Employee with benefits. Employer and Employee mutually agree as follows:

- I. Employee's per pay cash compensation shall be redirected by the amounts listed below effective the first pay period beginning on or after Employee becomes eligible for benefits and shall continue until this Agreement is amended or canceled. Employee's elections and participation shall be governed by the terms of the Dependent Care Reimbursement and Health Care Reimbursement Plans as amended from time to time.
- II. Redirected salary must reimburse expenses incurred during Plan Year and may not be carried into future years. Any amount not reimbursed for the current Plan Year will be returned to the Employer's general fund. If employment is terminated, this Agreement terminates; however, Employee retains the right to benefits in accordance with the Plan Document.
- III. By offering this Plan, the Employer has provided no tax advice regarding participation in this Plan, therefore, the Employee waives any claims against the Employer and holds the Employer harmless for any taxes or assessments that may be imposed by the Internal Revenue due to future interpretations or changes in the laws governing these Plans.

ACCEPTED BY EMPLOYEE

ACCEPTED BY EMPLOYER

Employee Signature _____ Date _____ EMPLOYER: _____ Date _____

Employee to Complete the Following:

Please deduct from EACH paycheck the following amounts for deposit to the designated flexible spending account:

INITIALS	BENEFITS	TOTAL DEDUCTION PER PAYCHECK
_____	Dependent Care Reimbursement	\$ _____/per paycheck (\$20 minimum)
_____	Health Care Reimbursement	\$ _____/per paycheck (\$20 minimum)