2010

CONCORDIA PLAN SERVICES
Your LCMS Benefits Partner

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

(I) EMPLOYER/EMPLOYEE INFORMATION

Group Name: Concordia University - St Paul ER07076 **Employer Number** 005703
Plan Year: 1/1/2010 **through** 12/31/2010

Employee Social Security Number:_____

Employee Name:_____
(Last, First, MI)

Home Address:_____

_____, _____ _____ - _____
(City) (St) (Zip)

Daytime Phone Number (__ __ __) __ __ __-__ __ __ __ **Date of Birth:**_____

Effective Date:_____**(To Be Provided by Group Contact)**

(II) ELECTIONS

Medical Flexible Spending Account
Plan Year Maximum of $ 5000

[ ] I want to contribute a total of $ _____ during this Plan Year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

Dependent Care Flexible Spending Account - for dependent child care and/or elder care
Plan Year Maximum of $ 5,000 ($2,500 if married but filing separate tax returns)

[ ] I want to contribute a total of $ _____ during this Plan Year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

I have reviewed the above election(s) and understand my choices will remain in effect for the entire Plan Year unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my account(s) at the end of the Plan Year will be forfeited.

_____ _____
Signature Date

P.O. Box 64193 St. Paul, MN 55164-0193 Phone (651) 662-5065/(800) 859-2144 Fax (651) 662-7247