FLEXIBLE BENEFIT ELECTION FORM
Town of Glastonbury
July 1, 2009 through June 30, 2010

The Flexible Benefit Plan allows you to make your contribution toward your benefits with pre-tax dollars. These dollars are not subject to FICA, federal or state income taxes. The plans covered by this agreement are listed in the **Summary Plan Description** and include the Flexible Spending Accounts listed below.

	MY ELECTION		
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT ***For reimbursement of eligible work-related child care or elder care expenses**** Maximum: $ 5000 per year (Single or Married, filing jointly) $ 2500 per year (Married, filing separately)	**Per pay-period** _____		**Per plan year** _____
MEDICAL CARE FLEXIBLE SPENDING ACCOUNT ***For reimbursement of eligible medical care expenses for you, your spouse and eligible tax dependents**** Minimum: $ 100 per year Maximum: $ 1500 per year	_____		_____

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above. I understand this agreement will remain in effect until the end of the plan year unless one of the following events occurs: A change in legal marital status due to marriage, divorce, legal separation, annulment, or my spouse's death; a change in the number of my federal tax dependents due to birth, adoption, placement for adoption, or death; a change in employment status for you, my spouse or federal tax dependent that affects benefits eligibility, such as termination or commencement of employment, a reduction or increase in hours worked, a strike or lockout, commencement of, or return from an unpaid leave of absence, or a change in worksite; an event that causes my dependent to satisfy or cease to satisfy status as a dependent; a change in my, my spouse's or my federal tax dependent's residence; special enrollment rights; certain judgments, decrees and orders; entitlement to Medicare or Medicaid; certain changes in cost; and certain changes in coverage. Each of these events are defined in the **Summary Plan Description** and any request for change will be governed by the terms outlined in the Summary Plan Description and the underlying group health plans (when applicable). I further understand that in the event the cost of a non-Flexible Spending account benefit I have selected changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

Employee Name (please print) _____ Social Security Number _____

Employee Date of Hire _____ Employee Date of Birth _____

Address _____ City _____ State _____ Zip _____

Daytime Phone Number (include area code) _____ Email Address _____

Employee Signature _____ Date _____

IRS regulations prohibit sole proprietors, partners, LLC members and greater than 2% subchapter S Corp. owners from participating in a flexible benefit plan.

Human Resources/Payroll please complete:

Effective Date _____ First P/R Date July 10, 2009 Payroll Cycle: W (B) S M