



**Flexible Spending Account
Enrollment Form
2009-2010**

Office Use Only

Pers.No

Eff. Date

Last Name	First Name	MI	Person ID or Soc. Sec. #	Sex	
Home Address	City	State	Zip Code	Home Phone	Work Phone

Account Allocation

	Total annual amount you wish to contribute
Health Care Reimbursement Account (\$250 min./\$4000 max.)	
Dependent Care Assistance Account (\$500 min./\$5000 max.)	

I wish to have my salary redirected for the period of July 1, 2009 through June 30, 2010 in each of the categories listed above. I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of University of Kentucky Flexible Spending Account (FSA) Program.

Signature: _____ Date _____

We recommend you keep a copy of the completed form for your records.

Return To:	Employee Benefits Office 112 Scovell Hall Lexington, KY 40506-0064
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ASI
1-(800)-659-3035
E-mail: asi@asiflex.com
Web: <http://www.asiflex.com>