Orange County Government
Section 125 Flexible Benefit Plan

2007 Flexible Spending Accounts Enrollment
Open Enrollment October 2, 2006 – October 31, 2006

PERIOD OF COVERAGE – 01/01/07 THROUGH 12/31/07

Name (print) _____

Street Address _____

City _____ **State**_____ **Zip Code**_____

SS# _____ - _____ - _____

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

1. HEALTH CARE FLEXIBLE SPENDING ACCOUNT (IRS 125)

( ) I hereby elect to make the following annual contribution to my health care Flexible Spending Account under the Plan and hereby agree that the annual contribution will be made in equal amounts each pay period through payroll deduction.

$_____ total for the plan year.

Note: The minimum annual deposit in the Health Care Flexible Spending Account is $300 and the maximum cannot exceed $3,000.

* Payroll Deductions to be made as follows:

26 pay periods , January 1st through December 31st if a full year; for new employees entering after January 1st, number of payroll contributions will vary.

Your dependents include **y**our spouse, your children under the age of 19 and your unmarried full-time student dependents ages 19 to 25.

Dependent(s) Information			
Last Name	**First Name**	**Date of Birth**	**Relationship**

(SEE REVERSE SIDE)

2. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (IRS 129)

( ) I hereby elect to make the following contribution to my Dependent Care Flexible Spending Account under the Plan and hereby agree that the annual contribution will be made in equal amounts each pay period, through payroll deduction.

$_____ total for the plan year.

Note: The minimum annual deposit in the Dependent Care Flexible Spending Account is $300 and the maximum cannot exceed $5,000. ($300 minimum and $2,500 for married participants who file separate returns.)

* Payroll Deductions to be made as follows:

26 pay periods , January 1st through December 31st if a full year; for new employees entering after January 1st, number of payroll contributions will vary.

Your dependents may be children under the age of 13, handicapped children, or adult parents who need care to allow you and your spouse to continue working.

Dependent(s) Information			
Last Name	**First Name**	**Date of Birth**	**Relationship**

I agree that my compensation will be reduced by the amount of my required contribution for the benefits I have elected under the Orange County Government Section 125 Flexible Benefit Plan, and that such salary reductions will continue for each pay period until this agreement is amended or terminated. I understand that:

- I cannot change or revoke this Salary Reduction Agreement as of any date prior to the next January 1, unless a Change in Status occurs (i.e., marriage, divorce, death of a spouse or dependent, birth or adoption of a child, termination or commencement of employment of a spouse and such other events as will permit a change or revocation of an election under the Internal Revenue Code, as amended) and the change is caused by and is consistent with the Change in Status.

- Salary Reductions under this Salary Reduction Agreement will reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.

- Amounts remaining in my Health FSA Account and Dependent Care Account after reimbursing my expenses for the Plan Year will be forfeited.

- During the annual open enrollment period each year, I will be offered the opportunity to change my Flexible Spending Account Elections. If I do not complete and return a new election form at that time, then I will be treated as having elected to discontinue participation in the Account(s), and my participation will cease at the end of the Plan Year (December 31st).

- If I am enrolled in the Health FSA, and go out on a Leave of Absence, I **must** notify Risk Management.

_____ _____

Signature of Participant Date