

**VALENCIA COMMUNITY COLLEGE  
SALARY REDIRECTION AGREEMENT FOR 2009**

NAME \_\_\_\_\_ EMPLOYEE ID# \_\_\_\_\_ V \_\_\_\_\_

**DIRECTIONS:** Use this form to change the contribution amount or enroll in a flexible spending account (Health Care and/or Dependent Care Reimbursement Accounts). Enter annual amounts in the spaces indicated below. This form can also be used to opt out of pre-taxed insurance premiums (see box to the right).

**Flexible Spending Accounts**

Check option to enroll in, make changes, or discontinue for 2009	Description	Annual Amount (min.-\$120; max-\$3,600)
	<b>Health Care Reimbursement (out-of-pocket medical expenses for employees and dependents)</b>	
	<b>Dependent Care Reimbursement (out-of-pocket dependent day care expenses)</b>	
	<b>I DO NOT want to participate in flexible spending account(s) as indicated above shown as a -0- in Annual Amount next to the acct.</b>	

Under the conditions specified in the Flexible Benefits Plan, I authorize Valencia Community College to redirect my salary in order to purchase the nontaxable benefits I have selected above or to cancel as I have indicated. I understand that any amounts in my accounts not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the choices I have selected above will be in effect for the plan year and cannot be revoked unless I experience a change in my eligibility or family status.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Premium Conversion Program**

Beginning January, 2009, premiums for Optional Benefits (dependent health & dental, etc.) will be automatically deducted before taxes. Premiums for domestic partner coverage will be deducted after taxes unless the domestic partner qualifies as a dependent. Disability coverage is also excluded from pre-taxed premiums. If you do not want premiums deducted before taxes, you must check the box below and sign where indicated.

**I do not want premiums for Optional Benefits deducted before taxes. Under the conditions specified in the Flexible Benefits Plan, I understand that this decision will be in effect for the plan year and cannot be revoked unless I experience a change in my eligibility or family status.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

<b>For Office Use Only</b>
Processed by: _____
Date: _____