

**BALDWIN-WALLACE COLLEGE  
FLEXIBLE BENEFITS ENROLLMENT FORM  
FOR THE PLAN YEAR JANUARY 1, 2012 – DECEMBER 31, 2012**

Name: \_\_\_\_\_  
(Please Type or Print)

Social Security Number: \_\_\_\_\_ Department: \_\_\_\_\_

New Enrollment

Change in Family Status

**Medical Reimbursement Account**

Per Pay, 2012 please deduct \$ \_\_\_\_\_  
**(24 pays for Bi-weekly, 12 pays for Monthly employees)**

Total for Plan Year 2012\* is \$ \_\_\_\_\_

\* Total for Medical Plan Year 2012 may not exceed \$5,000.00

**Dependent Care Reimbursement Account**

Per Pay, 2012 please deduct \$ \_\_\_\_\_  
**(24 pays for Bi-weekly, 12 pays for Monthly employees)**

Total for Plan Year 2012\* is \$ \_\_\_\_\_

\* Total for Dependent Care Plan Year 2012 may not exceed \$5,000.00

By signing below, I understand that I am authorizing Baldwin-Wallace College to reduce my compensation by the amount I have selected for the Medical and/or Dependent Care Reimbursement Account. I also understand that I may not change my selection for 2012, unless I have a change in family status, which would allow a new selection for 2012. I further understand that any amount remaining in the Medical and/or Dependent Care Reimbursement Account at the end of the Plan Year (December 31) that is not eligible for reimbursement will be forfeited.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

Medical and Dependent Claim Forms available at; [www.bw.edu/resources/hr/forms](http://www.bw.edu/resources/hr/forms) and in Human Resources.