BALDWIN-WALLACE COLLEGE
FLEXIBLE BENEFITS ENROLLMENT FORM
FOR THE PLAN YEAR JANUARY 1, 2011 – DECEMBER 31, 2011

Name: ____
(Please Type or Print)

Social Security Number: ______________ Department: ____________________

☐ New Enrollment ☐ Change in Family Status

Medical Reimbursement Account

Per Pay, 2011 please deduct $ __________
(24 pays for Bi-weekly, 12 pays for Monthly employees)

Total for Plan Year 2011* is $ __________

* Total for Medical Plan Year 2011 may not exceed $5,000.00

Dependent Care Reimbursement Account

Per Pay, 2011 please deduct $ __________
(24 pays for Bi-weekly, 12 pays for Monthly employees)

Total for Plan Year 2011* is $ __________

* Total for Dependent Care Plan Year 2011 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 2011, unless I have a change in family status, which would allow a new selection for 2011. 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** and in Human Resources.