

FLEXIBLE BENEFITS PLAN
ANNUAL ENROLLMENT FORM
 Plan Year 2004/2005 (July 1, 2004 - June 30, 2005)
 Election Change (attach Status Change form)

Section 125 of the Internal Revenue Code also establishes the opportunity for employees to pay certain eligible health care expenses (those for which reimbursement is not received from an insurance carrier) and dependent care expenses with tax-free dollars. The employee determines the amount to deduct from his/her check and to deposit into each of the two accounts. The Annual Target indicated below is used to determine the monthly deduction based on your Pay Type. See our website at www.lsu.edu/benefits for a complete description of the plan.

NOTE: For those employees who are nearing 40 years of service or who participate in Social Security, participation in a Flexible Benefits Plan may have an adverse effect on the computation of your Social Security benefits.

PREMIUM ONLY	
Elections for Premiums Only Plan will automatically renew each year unless changed during April Open Enrollment.	
<input type="checkbox"/> YES , I elect to PARTICIPATE in the Premiums Only Plan. I understand that eligible insurance premiums will be deducted pre-tax and this election will remain in effect and cannot be cancelled or changed during the plan year unless the cancellation or change is within the guidelines of Louisiana State University's Flexible Benefits Plan.	
<input type="checkbox"/> NO , I DO NOT elect to participate in the Premiums Only Plan. I understand that premiums will <u>not</u> be deducted on a pre-tax basis.	

SPENDING ACCOUNT	
Spending account elections must be renewed during the annual Open Enrollment period in April of each year.	
HEALTH CARE SPENDING ACCOUNT	DEPENDENT CARE SPENDING ACCOUNT
<input type="checkbox"/> I choose to participate in a Health Care Spending Account (Annual Maximum = \$3000; Annual Minimum = \$100) ANNUAL TARGET (must complete) _____ FOR EMPLOYEE USE ONLY: *Monthly amt for 9 mo. Employees _____ *Monthly amt for 12 mo. employees _____ *Monthly rate will be pro-rated by number of paychecks remaining in the year with a restricted amount of \$250/month for 12 month employees & \$333/month for 9 month employees.	<input type="checkbox"/> I choose to participate in a Dependent Care Spending Account (Annual Maximum = \$5000 or \$2500 if married and filing separately; Annual Minimum = \$100). ANNUAL TARGET (must complete) _____ FOR EMPLOYEE USE ONLY: *Monthly amt for 9 mo. employees _____ *Monthly amt for 12 mo. employees _____ *Monthly rate will be pro-rated by number of paychecks remaining in the year with a restricted amount of \$416/month for 12 month employees & \$555/month for 9 month employees. I understand that both my spouse and I must be employed or attending school full time, and that my election cannot be more than my annual salary or my spouse's, whichever is less, and that reimbursement from all employer plans cannot exceed \$5000.
<input type="checkbox"/> I choose NOT to participate in a Health Care Spending Account.	<input type="checkbox"/> I choose NOT to participate in a Dependent Care Spending Account
By enrolling in a spending account, I understand that: <ul style="list-style-type: none"> ▪ I agree to pay an administrative fee for participating in this plan in the amount of \$3 per month per account (maximum charge, \$6 per month). ▪ I authorize LSU A&M College to serve as administrator of my Health Care Spending Account and I direct that the administrative fee be paid to LSU A&M College. ▪ I authorize that the amount of my salary reduction for the Health Care Spending Account be deducted by LSU A&M College. ▪ My elections for the period cannot be changed unless my family status changes. ▪ Any money remaining in my account(s) at the end of the period will be forfeited. ▪ The deductions I have elected are made in accordance with the Plan Document and will be deducted in equal installments from my paychecks one month in advance. ▪ If a period of Leave Without Pay is anticipated while enrolled in Flexible Spending, please contact the Benefits Office. ▪ My monthly deduction will officially be determined by HRM based on my type of appointment and annual target I designate above. 	
I understand that these elections will be binding and that all changes must be made in accordance with the guidelines established in the Louisiana State University Flexible Benefits Plan and Section 125 of the Internal Revenue Code.	

Printed Name _____ Social Security Number _____

Signature _____ Date ____/____/____

RETURN THIS FORM TO THE HRM OFFICE NO LATER THAN APRIL 30, 2004