

**SAINT LOUIS UNIVERSITY**

**DEPENDENT CARE PLAN  
ENROLLMENT FORM**

**Maximum Enrollment: \$5,000**

**2008**

Name \_\_\_\_\_ Banner ID No. \_\_\_\_\_ SSN \_\_\_\_\_  
(Last) (First) (MI)

Home Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

I hereby elect to receive dependent care reimbursement(s) under the Saint Louis University Dependent Care Plan for the remainder of this Plan Year, beginning on my date of hire and ending December 31, 2008, and I agree to reduce my compensation for such period by:

\$ \_\_\_\_\_  
**total enrollment for the remainder of this calendar year**

I have received, read and understand the **Summary Plan Description** and I realize:

1. The total amount that I elect to contribute will be withheld from all remaining pay periods, beginning with my date of hire and ending December 31, 2008.
2. I am making a binding election for salary reduction for my eligible Plan Year that can only be changed if there is a qualifying change in family or employment status.
3. Reimbursement will be available only for dependent care expenses qualifying under Section 213 of the Internal Revenue Code.
4. This election form terminates on the last day of the Plan Year. Participation in any subsequent Plan Year requires a new election to be completed during the annual Open Enrollment period for the year involved.
5. Any benefits unused at the end of the Plan Year will be forfeited. I will have 90 days following the end of the Plan Year to submit claims for eligible expenses that were incurred during my Plan Year.

Signature \_\_\_\_\_ Date \_\_\_\_\_

FOR BENEFITS USE ONLY

MN / BW \$ \_\_\_\_\_ per pay period